

IDAHO ADMINISTRATIVE BULLETIN

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Volume 99-8

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Preface

The Idaho Administrative Bulletin is published once each month by the Department of Administration, Office of the Administrative Rules Coordinator, pursuant to Section 67-5203, Idaho Code. The Bulletin is a compilation of all administrative rulemaking documents in Idaho. The Bulletin publishes the official text notice and full text of such actions.

State agencies are required to provide public notice of rulemaking activity and invite public input. The public receives notice of a rulemaking activity through the Idaho Administrative Bulletin and the Legal Notice published monthly in local newspapers. The Legal Notice provides reasonable opportunity for public input, either oral or written, which may be presented to the agency within the time and manner specified in the Legal Notice. After the comment period closes, the agency considers fully all information submitted in regard to the rule. Comment periods are not provided in temporary or final rulemaking activities.

CITATION TO THE IDAHO ADMINISTRATIVE BULLETIN

The Bulletin is cited by year and issue number. For example, Bulletin 98-1 refers to the first Bulletin issued in calendar year 1998, Bulletin 99-1 refers to the first Bulletin issued in calendar year 1999, etc. Volume numbers, which proceed from 1 to 12 in a given year, correspond to the months of publication, i.e.; Volume No. 1 refers to January; Volume No. 2 refers to February; and so forth. Example: The Bulletin published in January of 1999 is cited as Volume 99-1. The December 1998 Bulletin is cited as Volume 98-12.

RELATIONSHIP TO THE IDAHO ADMINISTRATIVE CODE

*The Idaho Administrative Code is published once a year and is a compilation or supplemental compilation of all final and enforceable administrative rules in effect in Idaho. In an effort to provide the reader with current, enforceable rules, temporary rules are also published in the Administrative Code. Temporary rules and final rules that have been approved by the legislature during the legislative session, and published in the monthly Idaho Administrative Bulletin, supplement the Administrative Code. Negotiated, proposed, and pending rules are **not** printed in the Administrative Code and are published only in the Bulletin.*

*To determine if a particular rule remains in effect, or to determine if a change has occurred, the reader should refer to the **Cumulative Index of Administrative Rulemaking**, printed in each Bulletin.*

TYPES OF RULES PUBLISHED IN THE ADMINISTRATIVE BULLETIN

The state of Idaho administrative rulemaking process comprises five distinct activities; Proposed, Negotiated, Temporary, Pending, and Final rulemaking. In the majority of cases, the process begins with proposed rulemaking and ends with final rulemaking. The following is a brief explanation of each type of administrative rule.

NEGOTIATED RULE

Negotiated rulemaking is a process in which all interested parties and the agency seek a consensus on the content of the rule. Agencies are encouraged to proceed through this informal rulemaking whenever it is feasible to do so. Publication of the text in the Administrative Bulletin by the agency is optional. This process should lead the rulemaking to the temporary and/or proposed rule stage.

PROPOSED RULE

A proposed rulemaking is an action by an agency in which the agency is proposing to amend or repeal an existing rule or to adopt a new rule. Prior to the adoption, amendment, or repeal of a rule, the agency must publish a notice of proposed rulemaking in the Bulletin. The notice of proposed rulemaking must include:

- a) the specific statutory authority for the rulemaking including a citation to a specific federal statute or regulation if that is the basis of authority or requirement for the rulemaking;*
- b) a statement in nontechnical language of the substance of the proposed rule, including a specific description of any fee or charge imposed or increased;*
- c) the text of the proposed rule prepared in legislative format;*
- d) the location, date, and time of any public hearings the agency intends to hold on the proposed rule;*
- e) the manner in which persons may make written comments on the proposed rule, including the name and address of a person in the agency to whom comments on the proposal may be sent;*
- f) the manner in which persons may request an opportunity for an oral presentation; and*
- g) the deadline for public (written) comments on the proposed rule.*

As stated, the text of the proposed rule must be published in the Bulletin. After meeting the statutory rulemaking criteria for a proposed rule, the agency may proceed to the pending rule stage. A proposed rule does not have an assigned effective date unless published in conjunction with a temporary rule docket. An agency may vacate a proposed rulemaking if it decides not to proceed further with the promulgation process.

TEMPORARY RULE

Temporary rules may be adopted only when the governor finds that it is necessary for:

- a) the protection of the public health, safety, or welfare; or*
- b) compliance with deadlines in amendments to governing law or federal programs; or*
- c) conferring a benefit.*

If a rulemaking meets any one or all of the above requirements, a rule may become effective before it has been submitted to the legislature for review and the agency may proceed and adopt a temporary rule.

A temporary rule expires at the conclusion of the next succeeding regular session of the legislature unless the rule is approved, amended, or modified by concurrent resolution or when the rule has been replaced by a final rule.

In cases where the text of the temporary rule is the same as that of the proposed rule, the rulemaking can be done concurrently as a temporary/proposed rule. State law requires that the text of a proposed or temporary rule be published in the Administrative Bulletin. Combining the rulemaking allows for a single publication of the text.

An agency may rescind a temporary rule that has been adopted and is in effect if the rule is being replaced by a new temporary rule or has been published concurrently with a proposed rulemaking that is being vacated.

PENDING RULE

A pending rule is a rule that has been adopted by an agency under the regular rulemaking process and

remains subject to legislative review before it becomes a final, enforceable rule.

When a pending rule is published in the Bulletin, the agency is required to include certain information in the Notice of Pending Rule. This includes:

- a) the reasons for adopting the rule;
- b) a statement of any change between the text of the proposed rule and the pending rule with an explanation of the reasons for any changes;
- c) the date the pending rule will become final and effective; and
- d) an identification of any portion of the rule imposing or increasing a fee or charge.

Agencies are required to republish the text of the rule when substantive changes have been made to the proposed rule. An agency may adopt a pending rule that varies in content from that which was originally proposed if the subject matter of the rule remains the same, the pending rule is a logical outgrowth of the proposed rule, and the original notice was written so as to assure that members of the public were reasonably notified of the subject. It is not always necessary to republish all the text of the pending rule. With the permission of the Rules Coordinator, only the Section(s) that have changed from the proposed text are republished. If no changes have been made to the previously published text, it is not required to republish the text again and only the Notice of Pending Rule is published.

FINAL RULE

A final rule is a rule that has been adopted by an agency under the regular rulemaking process and is in effect.

No pending rule adopted by an agency will become final and effective until it has been submitted to the legislature for review. Where the legislature finds that the agency has violated the legislative intent of the statute under which the rule was made, a concurrent resolution will be adopted rejecting, amending, or modifying the rule or any part thereof. A Notice of Final Rule must be published in the Idaho Administrative Bulletin for any rule that is rejected, amended, or modified by the legislature showing the changes made. A rule that has been reviewed by the legislature and has not been rejected, amended, or modified will become final with no further legislative action. No rule shall become final and effective before the conclusion of the regular or special legislative session at which the rule was submitted for review. However, a rule which is final and effective may be applied retroactively, as provided in the rule.

AVAILABILITY OF THE ADMINISTRATIVE CODE AND BULLETIN

The Idaho Administrative Code and all monthly Bulletins are available for viewing and use by the public in all 44 county law libraries, state university and college and community college libraries, the state law library, the state library, the Public Libraries in Boise, Pocatello, Idaho Falls and Twin Falls, the Lewiston City Library, East Bonner County Library, Eastern Idaho Technical College Library, Ricks College Library, and Northwest Nazarene College Library.

SUBSCRIPTIONS AND DISTRIBUTION

For subscription information and costs of publications, please contact the Department of Administration, Office of the Administrative Rules Coordinator, 650 W. State Street, Room 100, Boise, Idaho 83720-0306, telephone

(208) 332-1820.

The Administrative Bulletin is an official monthly publication of the State of Idaho. Yearly subscriptions or individual copies are available for purchase.

The Administrative Code, is an annual compilation or supplemental compilation of all final and enforceable temporary administrative rules and includes tables of contents, reference guides, and a subject index.

Individual Rule Chapters and *Individual Rulemaking Dockets*, are specific portions of the Bulletin and Administrative Code produced on demand.

Internet Access - The Administrative Code and Administrative Bulletin are available on the Internet at the following address:

<http://www.state.id.us/> - from Idaho Home Page select the Administrative Rules link.

EDITOR'S NOTE: All rules are subject to frequent change. Users should reference all current issues of the Administrative Bulletin for negotiated, temporary, proposed, pending, and final changes to all rules, or call the Office of the Administrative Rules at (208) 332-1820.

HOW TO USE THE IDAHO ADMINISTRATIVE BULLETIN

Rulemaking documents produced by state agencies and published in the *Idaho Administrative Bulletin* are organized by a numbering system. Each state agency has a two-digit identification code number known as the "IDAPA" number. (The "IDAPA" Codes are listed in the alphabetical/numerical index at the end of this Preface.) Within each agency there are divisions or departments to which a two-digit "TITLE" number is assigned. There are "CHAPTER" numbers assigned within the Title and the rule text is divided among major sections with a number of subsections. An example IDAPA number is as follows:

IDAPA 38.05.01.060.02.c.ii.

"IDAPA" refers to Administrative Rules in general that are subject to the Administrative Procedures Act and are required by this act to be published in the Idaho Administrative Code and the Idaho Administrative Bulletin.

"IDAPA 38." refers to the Idaho Department of Administration.

"05." refers to Title 05 which is the Department of Administration's Division of Purchasing.

"01." refers to Chapter 01 of Title 05, "Rules of the Division of Purchasing".

"060." refers to Major Section 060, "Content of the Invitation to Bid".

"02." refers to Subsection 060.02.

"c." refers to Subsection 060.02.c.

"ii." refers to Subsection 060.02.c.ii.

DOCKET NUMBERING SYSTEM

Internally, the Bulletin is organized sequentially using a rule docketing system. All rulemaking actions (documents) are assigned a "DOCKET NUMBER". The "Docket Number" is a series of numbers separated by a hyphen "-", (38-0501-9901). The docket numbers are published sequentially by IDAPA designation (e.g. the two-digit agency code). The following example is a breakdown of a typical rule docket:

"DOCKET NO. 38-0501-9901"

"38-" denotes the agency's IDAPA number; in this case the Department of Administration.

"0501-" refers to the TITLE AND CHAPTER numbers of the agency rule being promulgated; in this case the Division of Purchasing (TITLE 05), "Rules of the Division of Purchasing" (Chapter 01).

"9901" denotes the year and sequential order of the docket submitted and published during the year; in this case the first rulemaking action of the chapter published in calendar year 1999.

Within each Docket, only the affected sections of chapters are printed. (See **Sections Affected Index** in each Bulletin for a listing of these.) The individual sections affected are printed in the Bulletin sequentially (e.g. Section "200" appears before Section "345" and so on). Whenever the sequence of the numbering is broken the following statement will appear:

"(BREAK IN CONTINUITY OF SECTIONS)"

INTERNAL AND EXTERNAL CITATIONS TO ADMINISTRATIVE RULES IN THE CODE AND BULLETIN

When making a citation to another Section or Subsection that is part of the same rule, a typical internal citation may appear as follows:

"...as found in Section 201 of this rule." OR "...in accordance with Subsection 201.06.c. of this rule."

It may also be cited to include the IDAPA, Title, and Chapter number also, as follows:

"...in accordance with IDAPA 38.05.01.201."

"38" denotes the IDAPA number of the agency.

"05" denotes the TITLE number of the agency rule.

"01" denotes the Chapter number of the agency rule.

"201" references the main Section number of the rule that is being cited.

Citations made within a rule to a different rule chapter (external citation) should also include the name of the Department and the name of the rule chapter being referenced, as well as the IDAPA, Title, and Chapter numbers. The following is a typical example of an external citation to another rule chapter:

"...as outlined in the Rules of the Department of Administration, IDAPA 38.04.04, 'Rules Governing Capitol Mall Parking.'"

BULLETIN PUBLICATION SCHEDULE FOR 1999

Volume No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date
99-1	January, 1999	November 18, 1998	January 6, 1999
99-2	February, 1999	December 23, 1998	February 3, 1999
99-3	March, 1999	January 20, 1999	March 3, 1999
99-4	April, 1999	February 24, 1999	April 7, 1999
99-5	May, 1999	March 24, 1999	May 5, 1999
99-6	June, 1999	April 21, 1999	June 2, 1999
99-7	July, 1999	May 26, 1999	July 7, 1999
99-8	August, 1999	June 23, 1999	August 4, 1999
99-9	September, 1999	July 21, 1999	September 1, 1999
99-10	October, 1999	August 25, 1999	October 6, 1999
99-11	November, 1999	September 22, 1999	November 3, 1999
99-12	December, 1999	October 20, 1999	December 1, 1999

BULLETIN PUBLICATION SCHEDULE FOR 2000

Volume No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date
00-1	January, 2000	November 17, 1999	January 5, 2000
00-2	February, 2000	December 22, 1999	February 2, 2000
00-3	March, 2000	January 19, 2000	March 1, 2000
00-4	April, 2000	February 23, 2000	April 5, 2000
00-5	May, 2000	March 22, 2000	May 3, 2000
00-6	June, 2000	April 19, 2000	June 7, 2000
00-7	July, 2000	May 24, 2000	July 5, 2000
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00-9	September, 2000	July 19, 2000	September 6, 2000
00-10	October, 2000	August 22, 2000	October 4, 2000
00-11	November, 2000	September 20, 2000	November 1, 2000
00-12	December, 2000	October 25, 2000	December 6, 2000

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55	Vocational Education, Division of - Administrative Code Volume 8
47	Vocational Rehabilitation, Division of - Administrative Code Volume 8
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42	Wheat Commission, Idaho - Administrative Code Volume 8

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.10 - RULES GOVERNING MEDICAID PROVIDER REIMBURSEMENT IN IDAHO
DOCKET NO. 16-0310-9902

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 1999.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) SB1074; 56-202(f), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 1999.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: These rules implement the provisions of Senate Bill 1074 (1999) which changes the method of payment for nursing homes in Idaho. These Rules become effective on the effective date of the legislation. The new reimbursement methodology changes to a prospective, acuity-based reimbursement system. These changes affect nearly all of the sections of nursing home reimbursement.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with deadlines in amendments to governing law or federal programs.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Robbie Charlton at (208) 364-1809.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 25, 1999.

DATED this 21st day of June, 1999.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 334-5548 fax

THE FOLLOWING IS TEXT OF DOCKET NO. 16-0310-9902

000. LEGAL AUTHORITY.

Title XIX (Medicaid) of the Social Security Act, as amended, is the basic authority for administration of the federal program (see 42 CFR Part 447). Title 56, Chapter 1, Idaho Code, establishes standards for provider payment. Section 56-202, Idaho Code, provides that the Department is responsible for administering the program. Further it authorizes the Department to take necessary steps for its proper and efficient administration. ~~(12-31-91)(7-1-99)T~~

01. General. (7-1-93)

a. Fiscal administration of the Idaho Title XIX Medicaid Program will be in accordance with these rules and the Federal (42 CFR Part 447 – ~~SSA HIM 15~~ Providers Reimbursement Manual (PRM) Part I and Part II, and ~~MSA PRG 19~~ HCFA Publication 15-1 and 15-2, which is hereby incorporated by reference. These materials are available from HCFA, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the internet @ <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html> and state rules, as amended. The provisions shall apply unless otherwise authorized. ~~This chapter is an outline of the general rules and applications thereof. Questions regarding specifics and exceptions should be directed to the Department.~~ (12-31-91)(7-1-99)T

b. Generally accepted accounting principles, concepts and definitions shall be followed in determining acceptable accounting treatments except as otherwise provided. (1-16-80)

02. ~~Implied Consent~~ Compliance As Condition Of Participation. Compliance with the provisions in this chapter, its amendments, and additions is required for participation in the Idaho Title XIX (Medicaid) Program. (12-31-91)(7-1-99)T

(BREAK IN CONTINUITY OF SECTIONS)

002. REIMBURSEMENT PROVISIONS FOR STATE OWNED OR OPERATED ICF/MR FACILITIES. Provisions of these rules do not apply to ICF/MR facilities owned or operated by the state of Idaho. Reimbursement of such facilities will be governed by the principles set forth in ~~HIM 15~~ the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars (\$5,000) ~~or less.~~ (7-1-97)(7-1-99)T

003. ADMINISTRATIVE APPEALS. Hearings will be conducted in conformance with IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings And Declaratory Rulings". (7-1-99)T

0034. DEFINITIONS.

01. Accrual Basis. An accounting system based on the matching principle. Revenues are recorded when they are earned; expenses are recorded in the period incurred. (1-16-80)

02. Allowable Cost. Costs which are reimbursable, and sufficiently documented to meet the requirements of audit. (1-16-80)

03. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (1-16-80)

04. Appraisal. The method of determining the value of property as determined by a MAI appraisal. The appraisal must specifically identify the values of land, buildings, equipment and goodwill. (9-15-84)

05. Assets. Economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles. (1-1-82)

06. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (1-16-80)

07. Bed-Weighted Median. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (7-1-99)T

078. Beneficiaries. Persons who are eligible for and receive benefits under federal health insurance programs such as Title XVIII and Title XIX. (1-16-80)

089. Betterments. Improvements to assets which increase their utility or alter their use. (1-16-80)

0910. Capitalize. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (1-16-80)

11. Case Mix Component. The portion of the facility's rate, direct care component, that is determined from quarterly case mix indices. The case mix component of a facility's rate is established at the beginning of each calendar quarter, based on the case mix indices calculated on the picture date of the preceding quarter. (7-1-99)T

12. Case Mix Index. A numeric score assigned to each facility resident, based on the resident's physical and mental condition, which projects the amount of relative resources needed to provide care to the resident. (7-1-99)T

a. Facility Wide Case Mix Index. The average of the entire facility's case mix indices identified at each picture date during the cost reporting period. If case mix indices are not available for applicable quarters due to lack of data, case mix indices from available quarters will be used. (7-1-99)T

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG's classification. Medicaid or non-Medicaid status will be based upon information contained in claims and MDS databases. To the extent that Medicaid identifiers are found to be incorrect at the time of the audit, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (7-1-99)T

c. State-Wide Average Case Mix Index. The simple average of all facilities "facility wide" case mix indices used in establishing the reimbursement limitation July 1 of each year. The state-wide case mix index will be calculated annually during each July 1 rate setting. (7-1-99)T

103. Common Ownership. An individual, individuals, or other entities which have equity, or evidence ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists when an individual or individuals possess ownership to the extent that significant control can be exercised. (~~1-16-80~~)(7-1-99)T

114. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (1-16-80)

15. Control. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution. (7-1-99)T

126. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or material which are related or so considered for cost-accounting purposes. (1-16-80)

17. Cost Component. The portion of the facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a facility's rate is established annually at July 1 of each year. (7-1-99)T

138. Cost Reimbursement System. A method of fiscal administration of Title XIX which compensates the provider on the basis of expenses incurred. (1-16-80)

149. Cost Report. A fiscal year report of provider costs required by the Medicare program and any revenues and supplemental schedules required by the Department. (~~12-28-89~~)(7-1-99)T

1520. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly

called income statements. (1-16-80)

21. Costs Related To Patient Care. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. (7-1-99)T

22. Costs Not Related To Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are not allowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (7-1-99)T

~~**1623. Customary Charges.**~~ Normal charge for an item or service. Customary charges are the regular rates for various services which are recorded for Medicare beneficiaries and charges to patients liable for such charges. Those charges are to be adjusted downward, where the provider does not impose such charges on most patients liable for payment on a charge basis or, fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt (see Chapter 3, Sections 310 and 312, PRM). (4-16-80)(7-1-99)T

~~**1724. Day Treatment Services.**~~ Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the provider. However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (7-1-97)

~~**1825. Department.**~~ The Department of Health and Welfare of the state of Idaho. (1-16-80)

~~**1926. Depreciation.**~~ The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (1-1-82)

27. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (7-1-99)T

a. Direct nursing salaries which include the salaries of registered nurses, licensed professional nurses, certified nurse's aides, and unit clerks; and (7-1-99)T

b. Routine nursing supplies; and (7-1-99)T

c. Nursing administration; and (7-1-99)T

d. Direct portion of Medicaid related ancillary services; and (7-1-99)T

e. Social services; and (7-1-99)T

f. Raw food; and (7-1-99)T

g. Employee benefits associated with the direct salaries. (7-1-99)T

~~**208. Director.**~~ The Director of the Department of Health and Welfare or his designee. (1-1-82)

~~**219. Equity.**~~ The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (9-15-84)

~~**2230. Facility.**~~ An entity which contracts with the Director to provide services to recipients in a structure owned, controlled, or otherwise operated by such an entity, and which entity is responsible for operational decisions

in conjunction with the use of the term "facility": (1-1-82)

a. The term "Nursing Facility" or "NF" is used to describe all non-ICF/MR facilities certified to provide care to Medicaid and Medicare patients; (2-1-91)

b. "Free-Standing Nursing Facility" means a skilled nursing facility, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in Section 39-1301(a), Idaho Code; or (9-28-90)

c. "Hospital-based facility" means a nursing facility, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which is owned, managed, or operated by, or is otherwise a part of a hospital, as defined in Section 39-1301(a), Idaho Code. (7-1-97)

d. "Rural Hospital-Based Nursing Facilities." Those hospital-based nursing facilities not located within metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (7-1-99)T

e. "Urban Hospital-Based Nursing Facilities." Those hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (7-1-99)T

231. Fiscal Year. The business year of an organization. (1-16-80)

2432. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (11-4-85)

2533. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (1-16-80)

2634. GAAP. Generally accepted accounting principles, pronounced "gap". (1-16-80)

2735. Generally Accepted Accounting Principles. Those concepts, postulates, axioms, etc., which are considered standards for accounting measurement. (1-16-80)

2836. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is nonallowable, nonreimbursable expense. (9-15-84)

307. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (1-1-82)

318. ICF/MR. An intermediate care facility for the mentally retarded. (9-15-84)

329. ICF/MR Living Unit. The specific property or portion thereof that an ICF/MR uses to house patients. (7-1-97)

3340. Improvements. Improvements to assets which increase their utility or alter their use. (1-16-80)

41. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (7-1-99)T

a. Administrative and general care costs: and (7-1-99)T

- b. Activities; and (7-1-99)T
- c. Central service and supplies; and (7-1-99)T
- d. Laundry and linen; and (7-1-99)T
- e. Dietary (non-"raw food" costs); and (7-1-99)T
- f. Plant operations and maintenance (excluding utilities); and (7-1-99)T
- g. Medical records; and (7-1-99)T
- h. Employee benefits associated with the indirect salaries; and (7-1-99)T
- i. Housekeeping; and (7-1-99)T
- j. Other costs not included in direct care costs or costs exempt from cost limits. (7-1-99)T

42. Inflation Adjustment. Cost used in establishing a facility's reimbursement rate shall be indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (7-1-99)T

43. Inflation Factor. For use in establishing nursing facility rates, the inflation factor is the Skilled Nursing Facility (SNF) Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. (7-1-99)T

344. Interest. The cost incurred for the use of borrowed funds. (1-16-80)

345. Interest On Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are differentiated from those related to current indebtedness by the payback period of the related debt. (1-16-80)

346. Interest On Current Indebtedness. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are differentiated from others by the fact that the related debt is scheduled for repayment within one (1) year. (1-16-80)

47. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (1%) at the date the loan is made. (7-1-99)T

3748. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (10-22-93)

3849. Intermediary. Any organization which administers the Title XIX program; in this case the Department of Health and Welfare. (1-16-80)

3950. Intermediate Care Facility For The Mentally Retarded. A habilitative facility designed and operated to meet the educational, training, habilitative and intermittent medical needs of the developmentally disabled. (9-15-84)

4051. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. (1-16-80)

4152. Lease. A contract arrangement for use of another's property, usually for a specified time period, in

return for period rental payments. (1-16-80)

4253. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (1-16-80)

4354. Level Of Care. The classification in which a patient/resident is placed following a medical/social review decision. (1-16-80)

4455. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (1-16-80)

56. Lower Of Cost Or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) shall be the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge shall be reimbursed fair compensation; which is the same as reasonable cost. (7-1-99)T

457. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (9-15-84)

4658. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (12-28-89)

- a. A relatively fixed location in the building; (11-4-85)
- b. Capable of being moved, as distinguished from building equipment; (11-4-85)
- c. A unit cost of five ~~hundred thousand~~ thousand dollars (\$5000) or more; (~~12-31-91~~)(7-1-99)T
- d. Sufficient size and identity to make control feasible by means of identification tags; and (11-4-85)
- e. A minimum life of ~~approximately~~ three (3) years. (~~11-4-85~~)(7-1-99)T

59. Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the document initially used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (7-1-99)T

4760. Medicaid. The 1965 amendments to the Social Security Act (P.L. 89-97), as amended. (1-1-82)

61. Medicaid Related Ancillary Costs. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (7-1-99)T

4862. Minor Movable Equipment. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen shall, at the facility's option, be considered minor movable equipment with the cost thereof reported as a medical supply. The general characteristics of this equipment are: (12-28-89)

- a. In general, no fixed location and subject to use by various departments of the provider's facility; (11-4-85)
- b. Comparatively small in size and unit cost under five ~~hundred thousand~~ thousand dollars (\$5000);

- ~~(12-31-91)~~(7-1-99)T
- c. Subject to inventory control; (11-4-85)
- d. Fairly large quantity in use; and (11-4-85)
- e. Generally, a useful life of approximately less than three (3) years ~~or less.~~ ~~(11-4-85)~~(7-1-99)T
- 63. Necessary.** The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (7-1-99)T
- 4964. Net Book Value.** The historical cost of an asset, less accumulated depreciation. (1-1-82)
- 65. New Bed.** A bed is considered new if it is an additional nursing facility bed that is licensed subsequent to July 1, 1999. (7-1-99)T
- 66. Nominal Charges.** A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (7-1-99)T
- 5067. Nonambulatory.** Unable to walk without assistance. (11-4-85)
- 5468. Nonprofit Organization.** An organization whose purpose is to render services without regard to gains. (1-1-82)
- 69. Normalized Per Diem Cost.** Refers to direct care costs that have been adjusted based on the facility's case mix index for purposes of making the per diem cost comparable among facilities. Normalized per diem costs are calculated by dividing the facility's direct care per diem costs by its facility-wide case mix index, and multiplying the result by the statewide average case mix index. (7-1-99)T
- 5270. Nursing Home Facility.** A "Nursing Facility" or "NF". See facility. (9-28-90)
- 71. Nursing Facility Inflation Rate.** The most specific skilled nursing facility inflation rate applicable to Idaho established by Data Resources, Inc. or its successor. If a state or regional index has not been implemented, the national index will be used. (7-1-99)T
- 72. Ordinary.** Ordinary means that the costs incurred are customary for the normal operation of the business. (7-1-99)T
- 573. Patient Day.** A calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care shall be deemed to exist. (1-1-82)
- 74. Picture Date.** A point in time when case mix indices are calculated for every facility based on the residents in the facility on that day. The picture date to be used for rate setting will be the first day of the second month of a quarter. The picture date from that quarter will be used to establish the facility's rate for the next quarter. (7-1-99)T
- 5475. Private Rate.** Rate most frequently charged to private patients for a service or item. (1-16-80)
- 2976. ~~HIM-15~~ PRM.** The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, HCFA Publications 15-1 and 15-2, which are incorporated by reference into these rules. ~~(1-16-80)~~(7-1-99)T
- 5577. Property Costs.** The total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (9-15-84)

5678. Property Rental Rate. A rate paid per Medicaid patient day to other than hospital based nursing homes in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/MR facilities. (7-1-97)

579. Proprietary. An organization operated for the purpose of monetary gains. (1-16-80)

580. Provider. A licensed and certified skilled nursing or intermediate care facility which renders care to Title XIX recipients. (1-16-80)

81. Prudent Buyer. A prudent buyer is one who seeks to minimize cost when purchasing an item of standard quality or specification (PRM, Chapter 2100). (7-1-99)T

82. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (7-1-99)T

83. Related To Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (7-1-99)T

84. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (7-1-99)T

5985. Reasonable Property Insurance. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year shall not be considered reasonable. (11-4-85)

6086. Recipient. An individual determined eligible by the Director for the services provided in the state plan for Medicaid. (1-1-82)

6487. Related Entities. The provider, to a significant extent, is associated or affiliated with, or is controlled by, or has control of another entity. (1-16-80)

88. Resource Utilization Groups (RUG's). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. For purposes of initial rate setting, RUG's III, version 5.12, 34 Grouper, nursing weights only, with index maximization will be used for grouping residents and is hereby incorporated into these rules. The RUG's Grouper is available from HCFA, 7500 Security Blvd., Baltimore, MD, 21244-1850. Subsequent versions of RUG's, or its successor, will be evaluated and may be incorporated into the rate setting process as necessary. (7-1-99)T

6289. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (1-16-80)

6390. Skilled Nursing Facility. A nursing care facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and certified as a "Nursing Facility" under Title XVIII. (9-28-90)

6491. Title XVIII. The Medicare program administered by the federal Social Security Administration. (1-16-80)

6592. Title XIX. The medical assistance program known as Medicaid administered by the state of Idaho, Department of Health and Welfare. (1-16-80)

6693. Utilities. All expenses for heat, electricity, water and sewer. (9-15-84)

(BREAK IN CONTINUITY OF SECTIONS)

050. CRITERIA FOR PARTICIPATION IN THE IDAHO TITLE XIX PROGRAM.

01. Application For Participation And Reimbursement. Prior to participation in the Medicaid Program the Licensure and Certification Section of the Division of Health, Department of Health and Welfare or its successor organization, certifies a facility for participation in the Program. Their recommendations are forwarded to the Division of Welfare, ~~Bureau Division~~ of Medicaid Policy or its successor organization, for approval. The ~~Bureau Division~~ of Medicaid Policy or its successor organization issues a provider number to the facility which becomes the primary provider identification number. The ~~Bureau Division~~ of Medicaid Policy or its successor organization will need to establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. ~~(12-31-91)(7-1-99)T~~

02. Reimbursement. The reimbursement mechanism for payment to provider facilities is specified in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Rules Governing Medical Assistance". The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. (4-28-89)

(BREAK IN CONTINUITY OF SECTIONS)

062. PROPERTY REIMBURSEMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR CLASS).

Beginning October 1, 1996, property costs of an ICF/MR shall be reimbursed in accordance with Section 060 of these rules except as follows: (7-1-97)

01. Restrictions. No grandfathered rates or lease provisions other than lease provisions in Section 062 of these rules will apply to ICF/MR facilities. (7-1-97)

02. Home Office And Day Treatment Property Costs. Distinct parts of buildings containing ICF/MR living units may be used for home office or day treatment purposes. Reimbursement for the property costs of such distinct parts may be allowed if these areas are used exclusively for home office or day treatment services. The portion of property cost attributed to these areas may be reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for home office and day treatment property costs shall not include costs reimbursed by, or covered by the property rental rate. Such costs shall only be reimbursed as property cost if the facility clearly included space in excess of space normally used in such facilities. At a minimum to qualify for such reimbursement, a structure would have square feet per licensed bed in excess of the average square feet per licensed bed for other ICF/MR living units within four (4) licensable beds. (7-1-97)

03. Leases For Property. Beginning October 1, 1996, ICF/MR facilities with leases will be reimbursed as follows: (7-1-97)

a. The property costs related to ICF/MR living units other than costs for major movable equipment will be paid by a property rental rate in accordance with Sections 060 and 062 of these rules. (7-1-97)

b. Leases for property other than ICF/MR living units will be allowable based on lease cost to the facility not to exceed a reasonable market rate, subject to other provisions of this chapter, and ~~HIM-15 PRM~~ principles including principles associated with related party leases. ~~(7-1-97)(7-1-99)T~~

(BREAK IN CONTINUITY OF SECTIONS)

100. REASONABLE COST PRINCIPLES.

01. Principle. To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to beneficiaries will result. (1-16-80)

~~**02. Definitions.**~~ (7-1-93)

~~a. Reasonable means that the consideration given is an amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.~~ (1-16-80)

~~b. Ordinary means that the costs incurred are customary for the normal operation.~~ (1-16-80)

~~e. Necessary means that the services or goods purchased are required by law, prudent management, and for the normal operation of patient related business.~~ (1-16-80)

032. Application. (12-31-91)

a. Reasonable costs of any services are determined in accordance with rules found in Sections 250 through 299 and ~~Health Insurance Provider Reimbursement Manual 15 (HIM 15) (PRM)~~, Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (12-31-91)(7-1-99)T

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (1-16-80)

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (1-16-80)

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Idaho Code, or are unallowable by application of promulgated regulation. (11-4-85)

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (11-4-85)

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (1-16-80)

043. Costs Related To Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Example: Depreciation is a method of systematically recognizing the declining utility value of an asset. To the extent that the asset is related to patient care, reasonable, ordinary, and necessary, the related expense is allowable when reimbursed based on property costs according to other provisions of this chapter. Property related expenses are likewise allowable. (12-31-91)

054. Costs Not Related To Patient Care. Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. Example: Fines are imposed for late remittance of federal withholding taxes. Such fines are not related to patient care, are not necessary, and are not reflective of prudent cost conscious management. Therefore, such fines and penalties are not allowable. (1-1-82)

065. Form And Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. Example: Lease-Purchase agreements are contracts which are executed in the form of a lease. The wording of the contract is couched in such a manner as to give the reader the impression of a true rental-type lease. However, the substance of this contract is a purchase of the property (see Subsection 354.04.c.iii.). If a lease contract is found to be in substance a purchase, the related payments are not allowable as lease or rental expense. (12-31-91)

(BREAK IN CONTINUITY OF SECTIONS)

110. ALLOWABLE COSTS.

Below is a list of the normally allowable costs, and the related definitions and explanations, which includes, but is not limited to, the following items: (7-1-97)

01. Auto And Travel Expense. Expense of maintenance and operation of a vehicle and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement will not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported on. Meal reimbursement will be limited to the amount that would be allowed by the state for a Department employee. Entertainment expense is allowable only if documentation is provided naming the individuals and stating the purpose of the meeting. Entertainment expense is allowable only for patient care related purposes. (7-1-97)

02. Bad Debts. Payments for efforts to collect past due Title XIX accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX coinsurance amounts are one hundred percent (100%) reimbursable (~~HIM-15 PRM, Section 300.~~ ~~(1-16-80)~~(7-1-99)T

03. Bank And Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (1-16-80)

04. Contracted Service. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (1-16-80)

05. Depreciation. Depreciation on buildings and equipment is an allowable property expense for hospital-based facilities. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (10-22-93)

06. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See ~~HIM-15 PRM, Chapter 21 for specifics.~~ ~~(1-16-80)~~(7-1-99)T

07. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (1-16-80)

08. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (7-1-97)

09. Lease Or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, shall be reimbursed in the same manner as an owned asset. The cost of leases related to home offices and ICF/MR day treatment services shall not be reported as property costs and shall be allowable based on reasonable cost principles subject to other limitations contained herein. (7-1-97)

- 10. Payroll Taxes.** The employer's portion of payroll taxes is reimbursable. (1-6-80)
- 11. Property Costs.** Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. A property rental rate will be paid in lieu of costs in some circumstances according to other provisions of these rules. (7-1-97)
- 12. Property Insurance.** Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (11-4-85)
- 13. Repairs And Maintenance.** Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (1-16-80)
- 14. Salaries.** Salaries and wages of all employees engaged in patient care activities or overall operation and maintenance of the facility, including support activities of home offices, shall be allowable. (1-16-80)
- 15. Supplies.** Cost of supplies used in patient care or providing services related to patient care are allowable. (1-16-80)
- 16. Taxes.** Property taxes on assets used in rendering patient care are allowable. Other taxes may be allowable. Specifics are covered in the Provider Reimbursement Manual, ~~SSA-HIM-15 PRM~~, Chapter 21. Tax penalties are not allowable. ~~(1-1-82)~~(7-1-99)T
- 17. Compensation Of Owners.** An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation shall not exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation shall not exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Sections 402 and 403 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (7-1-97)
- a. Salaries wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (7-1-97)
 - b. Supplies and services provided for the owner's personal use. (1-16-80)
 - c. Compensation paid by the facility to employees for the sole benefit of the owner. (1-16-80)
 - d. Fees for consultants, directors, or any other fees paid regardless of the label. (1-16-80)
 - e. Keyman life insurance. (1-16-80)
 - f. Living expenses, including those paid for related persons. (1-16-80)

(BREAK IN CONTINUITY OF SECTIONS)

115. NONALLOWABLE COSTS.

In the absence of convincing evidence to the contrary, expenses listed below will be considered nonreimbursable. (1-16-80)

01. **Charity Allowances.** Cost of free care or discounted services. (1-16-80)
02. **Nonpatient Care Related Activities.** All activities not related to patient care. (1-16-80)
03. **Accelerated Depreciation.** Depreciation in excess of straight line except as otherwise provided (see Subsection 354.04.c.ii.). (12-31-91)
04. **Related Party Interest.** Interest on related party loans (see ~~HIM-15 PRM~~, Sections 218.1 and 218.2). ~~(1-16-80)~~(7-1-99)T
05. **Related Party Nonallowable Costs.** All costs not allowable to providers are not allowable to a related party, whether or not they are allocated. (1-16-80)
06. **Acquisitions.** Cost of corporate acquisitions, e.g., purchase of corporate stock as an investment. (1-16-80)
07. **Holding Companies.** All home office costs associated with holding companies are not allowable (~~HIM-15 PRM~~, Section 2150.2A). ~~(1-16-80)~~(7-1-99)T
08. **Related Party Refunds.** All refunds, allowances, terms, etc., shall be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. (1-16-80)
09. **Fund Raising.** Certain fund raising expenses (~~HIM-15 PRM~~, Section 2136.2). ~~(1-16-80)~~(7-1-99)T
10. **Vending Machines.** Costs of vending machines. Barber and beauty shops. (1-16-80)
11. **Organization.** Organization costs (see ~~HIM-15 PRM~~, Section 2134 and subsections of Section 2134 for specifics). ~~(1-16-80)~~(7-1-99)T
12. **Fees.** Franchise fees (~~HIM-15 PRM~~, Section 2133.1). ~~(1-16-80)~~(7-1-99)T
13. **Medicare Costs.** All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services. (7-1-98)
14. **Yellow Pages Advertising.** Telephone book yellow page advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in. (1-1-82)
15. **Consultant Fees.** Costs related to the payment of consultant fees in excess of the lowest rate available to a facility. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants and/or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Information obtained from consultants will be provided to facilities. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified pursuant to Subsection 115.15.b., unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This Subsection in no way limits the Department's ability to disallow excessive consultant costs under other Sections of this chapter, such as Section 100 or 121, when applicable. (7-1-97)
16. **Goodwill.** Costs associated with goodwill as defined in Subsection 003.27 of these rules. (7-1-97)
17. **Interest.** Interest to finance nonallowable costs. (7-1-97)
18. **Property Costs.** Costs reimbursed based on a property rental rate according to other provisions of these rules. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

150. RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (1-16-80)

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, ~~SSA-HM PRM~~ Chapter 10 and other applicable chapters of ~~HIM-15~~ the PRM. (7-1-97)(7-1-99)T

~~151. DEFINITIONS.~~

~~**01. Reasonable.** The consideration given for goods or services in the amount that would be acceptable to an independent buyer and seller in the same transaction. (1-16-80)~~

~~**02. Necessary.** The purchase that is required for normal, efficient and continuing operation of the business.— (1-16-80)~~

~~**03. Costs Related To Patient Care.** All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. (1-16-80)~~

~~**04. Costs Not Related To Patient Care.** Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are not allowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing home.— (1-16-80)~~

~~**05. Related To Provider.** The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (1-16-80)~~

~~**06. Common Ownership.** Exists when an individual or individuals possess ownership to the extent that significant control can be exercised. (1-16-80)~~

~~**07. Control.** Exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution. (1-16-80)~~

~~**08. Prudent Buyer.** A prudent buyer is one who seeks to minimize cost when purchasing an item of standard quality or specification (SSA-HM-15, Chapter 2100). (1-16-80)~~

1521. APPLICATION.

01. Determination Of Common Ownership Or Control In The Provider Organization And Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (1-16-80)

a. Common Ownership Rule. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (1-1-82)

b. Control Rule. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise (see control definition in Subsection 151.07). (12-31-91)

02. Cost To Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (1-16-80)

03. Costs Not Related To Patient Care. All home office costs not related to patient care are not allowable under the Program. (1-16-80)

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See ~~HIM-15 PRM~~ and Chapters 2, 10 and 12 for specifics. ~~(1-16-80)~~(7-1-99)T

1532. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.

An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary. (1-16-80)

01. Supplying Organization. That the supplying organization is a bona fide separate organization. (1-16-80)

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. (1-16-80)

1543. SALES AND RENTAL OF HOSPITALS OR EXTENDED CARE FACILITIES.

The exception is not applicable to sales, lease or rentals of hospital facilities and nursing homes or extended care facilities. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished (~~HIM-15 PRM~~, Sections 1008 and 1012). ~~(1-16-80)~~(7-1-99)T

01. Rentals. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (1-16-80)

02. Purchases. When a facility is purchased from a related entity, the purchaser's depreciable basis shall not exceed the seller's net book value (~~HIM-15 PRM~~, Section 1005). ~~(1-16-80)~~(7-1-99)T

1554. INTEREST EXPENSE.

Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See ~~HIM-15 PRM~~, Chapter 2 for specifics. ~~(1-16-80)~~(7-1-99)T

1565. -- 199. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

202. APPLICATION.

01. Cost Report Requirements. The fiscal year end cost report filing must include: (12-28-89)

a. Annual income statement (two (2) copies); (1-16-80)

b. Balance sheet; (1-16-80)

c. Statement of ownership; (1-16-80)

- d. Schedule of patient days; (1-16-80)
- e. Schedule of private patient charges; (1-16-80)
- f. Statement of additional charges to residents over and above usual monthly rate; and (1-16-80)
- g. Other schedules, statements, and documents as requested. (1-16-80)
- 02. Cost Statement Requirements.** Quarterly and short period cost statement filings must include: (12-28-89)
 - a. Filed not later than sixty (60) days after the close of the period. Reports received after this time will be accepted at the option of the Department. (1-16-80)
 - b. Statement of current costs to include at least one (1) quarter (or adjusted quarter, if applicable). Statement may also be filed for any period beginning and ending with quarters of the provider's fiscal year. Other reporting period may be requested. (1-16-80)
 - c. Schedule of patient days. (1-16-80)
 - d. Schedule of all patient charges. (1-16-80)
 - e. Other schedules, statements, and clarifications as requested. (1-16-80)
- 03. Special Reports.** Special reports may be required. Specific instructions will be issued, based upon the circumstance. (1-16-80)
- 04. Criteria.** All reports must meet the following criteria: (1-16-80)
 - a. State approved formats must be used. (1-16-80)
 - b. Presented on accrual basis. (1-16-80)
 - c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (1-16-80)
 - d. Appropriate detail must be provided on supporting schedules or as requested. (1-1-82)
- 05. Preparer.** It is not required that any statement be prepared by an independent, licensed or certified public accountant. (1-16-80)
- 06. Reporting By Chain Organizations Or Related Party Providers.** Section 2141.7, ~~SSA-HM-15 PRM~~, "Providers Reimbursement Manual" prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. ~~(1-16-80)~~(7-1-99)T
- 07. Change Of Management Or Ownership.** To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements shall be met: (1-16-80)
 - a. Outgoing management or administration shall file an adjusted-period cost report. This report shall meet the criteria for annual cost reports, except that it shall be filed not later than sixty (60) days after the change in management or ownership. (12-28-89)
 - b. Incoming managers or owners shall be required to report on the same basis as a new provider (see Section 203). (12-31-91)

- c. The Department may require an appraisal at the time of a change in ownership. (9-15-84)

203. REPORTING PERIOD.

When required for establishing rates, ~~New~~ providers will be required to submit three (3) quarterly cost statements, including one (1) adjusted-quarter report (if applicable), before the annual reporting option may be exercised. If a provider enters the program at some point in midquarter, his first quarter reporting dates will be adjusted to reflect not less than two (2) months operation nor more than four (4). Thereafter the normal reporting period would apply. If a provider withdraws from the program and subsequently re-enters, the new provider reporting requirements will apply. ~~(4-28-89)~~ (7-1-99)T

(BREAK IN CONTINUITY OF SECTIONS)

208. REPORTING FORMS.

Unless prior approval is granted, only state forms will be acceptable. Requests for approval of alternate forms must be in writing accompanied by samples. Such requests will not be considered adequate reason for late filing, or granting of a waiver, except in extraordinary circumstances as determined by the intermediary. Following is a partial listing of the account titles used on the state forms. Included also is an explanation of the classification and reporting standards applicable to that account. The report form may be revised periodically to meet changing Department and provider needs and may be in electronic format at the discretion of the Department. Reported costs shall only include allowable costs unless the Department structures the report to remove nonallowable costs by cost groupings, in which case, reported total and subtotal costs shall reflect net allowable costs except for the nonreimbursable section of the report. (7-1-97)

01. Revenues. The categories are self-explanatory. They are intended to give sufficient breakdown of revenues to effect the reasonable cost principles embodied in the cost reporting system. Facilities may also use the cost center approach of the statement to evaluate the expense of certain cost centers in respect to their revenue. (1-16-80)

02. Expenses. (7-1-93)

a. Administrative. (12-31-91)

i. Salaries: Administrator. Included in this category are salaries paid for administrators and assistant administrators of the facility. Any compensation in excess of the amount allowable under other provisions of this chapter shall be entered in the nonreimbursable Section of the cost statement (see Subsection 110.17 of these rules). (7-1-97)

ii. Salaries: Office and Clerical. Salaries and wages paid to clerks, bookkeepers, and others whose duties relate to overall operation of the facility, should be included in this account. (1-16-80)

iii. Payroll Taxes. The provider's portion of payroll taxes for all employees except those taxes related to the payroll for persons providing day treatment services to ICF/MR patients shall be included in the report categories provided for such costs. Payroll taxes for employees providing day treatment services to ICF/MR patients shall be reported in categories provided for these expenses. Self employment taxes related to owners are nonallowable and should not be included. (7-1-97)

iv. Employee Benefits. Expenses incurred such as sick pay and vacation pay should be included in this account except for those expenses relating to persons providing day treatment services for ICF/MR patients. Employee benefits for these employees should be reported in cost categories provided for those expenses. (7-1-97)

v. Accounts Collections. The expenses related to collection of past due program accounts such as legal fees, bill collectors, etc., are allowable. Allowances for bad debts and bad debt write-off are not allowable, and should be included in the Section titled Nonreimbursable Expenses. (4-28-89)

- vi. Auto and Travel. These expenses shall be those incurred in the operation of vehicles and other travel expense related to patient care. Normally, entertainment shall not be involved, but shall be recorded in the Section under Nonreimbursable Expenses (see ~~HIM-15~~ PRM, Chapter 21). ~~(1-16-80)~~ (7-1-99)T
- vii. Bank and Finance Charges. Normally recurring minor charges for handling of accounts shall be included here. (1-16-80)
- viii. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care or for general patient use, license fees (not including franchises), and dues to professional health care organizations are to be included. Dues, tuitions and educational fees to facilitate quality health care services are includable where the provisions of ~~HIM-15~~ PRM, Section 400, are met. ~~(1-16-80)~~ (7-1-99)T
- ix. Employee Recruitment. Costs of advertising for new employees shall be recorded in this account including applicable entertainment costs. (1-16-80)
- x. Home Office Costs. Costs allocated by related entities for various services shall be included in this account. (1-16-80)
- xi. Malpractice/Public Liability Insurance. Premiums for malpractice and public liability insurance shall be included in this account. (1-16-80)
- xii. Purchased Services. Costs of legal, accounting, and management services (not including related entities) for overall operations shall be included in this account. (1-16-80)
- xiii. Supplies and Rentals. Cost of supplies, postage, ledger sheets, and rental of minor office equipment shall be included in this account. (1-16-80)
- xiv. Telephone and Communications. Cost of telephone and related communications shall be included in this account. (1-16-80)
- xv. Interest, Working Capital. Allowable interest expense for loans not related specifically to the purchase of the real or personal property of the provider shall be reported here. (1-1-82)
- xvi. Miscellaneous. Any expense not properly allocable to other cost centers and not properly classified in other classification of administration expenses shall be included here. (1-16-80)
- b. Property. Property costs shall be reported by all facilities including those facilities which are reimbursed a property rental rate. (11-4-85)
- i. Amortization. Amortization of leasehold improvements shall be included here. Certain others may be included here also. (1-16-80)
- ii. Depreciation on Fixed Assets. Depreciation expenses for buildings and fixtures should be included here. Any depreciation in excess of straight line AHA lives shall not be included unless otherwise waived by the Department. Such excess shall be included in the Section of Nonreimbursable Expenses. (7-1-97)
- iii. Depreciation of Equipment. Depreciation expense for moveable equipment shall be included here. Excess depreciation as defined above shall be included in the Nonreimbursable Section (see Subsection 354.04.c.). ~~(12-31-91)~~
- iv. Interest Expense. Interest expense related to purchase of land, buildings and equipment related to patient care shall be included here only if it is payable to unrelated entities. Generally, interest payable to related entities shall be included in the Nonreimbursable Section (~~HIM-15~~ PRM, Section 202.3). ~~(11-4-85)~~ (7-1-99)T
- v. Insurance. Insurance premiums for property insurance such as fire and glass shall be includable here. (1-16-80)

- vi. Lease and Rental Payments. Payments for lease or rental of buildings, land and for equipment shall be includable here. (1-16-80)
- vii. Taxes. Taxes on property related to patient care shall be recorded in this account. (1-16-80)
- c. Patient Care Service. (1-16-80)
 - i. Nursing Care. (1-16-80)
 - (1) Salaries. Director of Nursing. Salaries or wages of the Director of Nursing shall be included here. (1-16-80)
 - (2) Registered Nurse. Salaries and wages of registered nurses shall be included in this account. Payroll taxes shall not be included but overtime shall be. (1-16-80)
 - (3) Licensed Professional Nurses. Wages for licensed professional nurses shall be included in this account including overtime, but not including payroll taxes. (1-16-80)
 - (4) Aides/Orderlies. Normal overtime and wages for aides and orderlies, not to include payroll taxes, shall be included in this account. (1-16-80)
 - (5) Contracted Services. Payments for patient health care services under contract shall be entered here. (1-16-80)
 - ii. Therapy Services. (1-16-80)
 - (1) Salaries. Salaries for all therapy personnel shall be recorded here. (1-16-80)
 - (2) Professional Services. Payments for contracted therapy services shall be recorded here. (1-16-80)
 - (3) Supplies and Miscellaneous. Expenses for supplies and miscellaneous expenses related to therapy and recreational therapy services shall be recorded here. (1-16-80)
 - iii. Social Services. (1-16-80)
 - (1) Salaries. Wages and salaries for activity directors and social services personnel shall be recorded here. (1-16-80)
 - (2) Contracted Services. Payments under contract arrangement for activities director or other social services personnel shall be included here. (1-16-80)
 - iv. Payroll Taxes and Employee Benefits. The payroll taxes and cost of employee benefits related to the salaries reported in Section 208 of these rules should be reported here. (7-1-97)
 - v. Costs Not Subject to the Percentile Cap. (12-31-91)
 - (1) Special Needs. Those costs determined by the Department and authorized under Section 56-117, Idaho Code, will be excluded from other reported costs and will be reported here (see Subsection 254.08). (12-31-91)
 - (2) Excluded Costs. Increases in costs otherwise subject to a cap incurred by facilities as a result of changes in legislation or regulations will be excluded from costs reported in categories subject to the cap and will be reported here (see Subsection 254.09). (7-1-97)
- d. Facility Operations and Services. (1-16-80)
 - i. Central Supply. (1-16-80)

- (1) Salaries: Pharmacist. Salaries and wages of pharmacists who are regular employees of the facility shall be included here, but are not reimbursable. (1-16-80)
- (2) Salaries. Salaries and wages of others, such as stock clerks, shall be recorded here. (1-16-80)
- (3) Contracted Services. Payments for services under contract will be recorded in this category, not including pharmaceutical services. (1-16-80)
- (4) Supplies and Miscellaneous. Miscellaneous expenses and routine nursing supplies such as laxatives, aspirin, and dressings shall be recorded here; the cost of oxygen concentrators may also be recorded here. Cost of prescription drugs must not be included. (12-28-89)
- ii. Laundry and Linen. (1-16-80)
- (1) Salaries. Salaries and wages for personnel involved in laundry operations shall be recorded here. (1-16-80)
- (2) Purchased Services. Costs of contracted linen services shall be recorded here. (1-16-80)
- (3) Linens and Bedding. Purchase of sheets, mattress pads, blankets, towels, etc., shall be entered here. Costs of beds and mattresses are capitalizable and should be treated accordingly. (1-16-80)
- (4) Miscellaneous Expenses. Miscellaneous expenses not properly classified in other areas of Section 208 should be included in this account. (12-31-91)
- e. Dietary. (1-16-80)
- i. Salaries: Dietitian. Wages of a dietitian who is a regular employee shall be included here. (1-16-80)
- ii. Salaries: Other. Salaries of cooks and other dietary personnel should be recorded here. (1-16-80)
- iii. Purchased Services. Payments for contracted dietary services, or dietitians, shall be included here. (1-16-80)
- iv. Food. Cost of food used for the period will be included here not including vending machine items. For purposes of reasonable cost evaluation, revenues from meals sold to nonpatients will reduce food costs and should be reported in the revenue Section. (1-16-80)
- v. Supplies. Cost of dietary supplies other than food should be recorded here. Do not include vending machine items. (1-16-80)
- f. Plant Operations and Maintenance. (1-16-80)
- i. Salaries. Wages of all housekeeping and maintenance employees shall be included in this account. (1-16-80)
- ii. Repairs and Maintenance. Cost of minor repairs to buildings and equipment shall be recorded here. (1-16-80)
- iii. Purchased Services. Costs of maintenance and repair services purchased under contract arrangements shall be recorded here. (1-16-80)
- iv. Utilities. Expenses for heat, electricity, water and sewer shall be included in this account. (9-15-84)
- v. Supplies and Miscellaneous. Expense of supplies and other unclassified expenses should be included here. (1-16-80)

g. Nonreimbursable Expenses. This classification of expenses is provided to reconcile your cost statement to books of record. It will also help the facility to determine its reasonable costs and anticipate its revenues. Routine business expenses not includable in the reasonable cost formula are to be recorded in Section 208. The account titles are indicative of these costs which are commonly found. (12-31-91)

03. Home Office Reporting. The purpose of the provisions of Section 208, is to support the costs allocated to the provider facility. A report is required for each level of organization which allocates costs to the provider, directly or indirectly. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

240. PROSPECTIVE RATES FOR ICF/MR.

Sections 240 through 246~~7~~ of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/MR providers. Total payment will include the following components: Property reimbursement, capped costs, an efficiency increment, exempt costs, excluded costs. (~~7-1-97~~)(7-1-99)T

241. PRINCIPLE.

Providers of ICF/MR facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider will report these cost items in accordance with other provisions of this chapter or the applicable provisions of ~~HM-15~~ PRM to the extent not inconsistent with this chapter. (~~7-1-97~~)(7-1-99)T

242. PROPERTY REIMBURSEMENT.

Beginning October 1, 1996, ICF/MR property costs are reimbursed by a rental rate or based on cost. The following shall be reimbursed based on cost as determined by the provisions of this chapter and applicable provisions of ~~HM-15~~ PRM to the extent not inconsistent with this chapter: ICF/MR living unit property taxes, ICF/MR living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and shall not be reported in the property cost portion of the cost report. These costs shall be reported in the home office and day treatment section of the cost report. Property costs, including costs which are reimbursed based on a rental rate, shall be reported in the property cost portion of the cost report. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. Property costs include the following components: (~~7-1-97~~)(7-1-99)T

01. Depreciation. Allowable depreciation based on straight line depreciation. (7-1-97)

02. Interest. All allowable interest expense which relates to financing depreciable assets. Interest on working capital loans is not a property cost and is subject to the cap. (7-1-97)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances are not property costs. (7-1-97)

04. Lease Payments. All allowable lease or rental payments. (7-1-97)

05. Property Taxes. All allowable property taxes. (7-1-97)

06. Costs Of Related Party Leases. Costs of related party leases are to be reported in the property cost categories based on the owner's costs. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

244. EFFICIENCY INCREMENT FOR ICF/MR.

An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap. ~~(7-1-97)~~(7-1-99)T

01. Computing Efficiency Increment. The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents (\$.20) per one dollar (\$1) below the cap up to a maximum increment of three dollars (\$3) per patient day. (7-1-97)

02. Determining Reimbursement. Total reimbursement determined by adding amounts determined to be allowable, shall not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and ~~HIM-15~~ PRM. In computing patient days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the patient is making payment for holding a bed in the facility, the patient will not be considered to be discharged and thus those days will be counted in the total. ~~(7-1-97)~~(7-1-99)T

(BREAK IN CONTINUITY OF SECTIONS)

250. PROSPECTIVE CAPS COST LIMITS FOR NURSING FACILITIES.

Sections 250 through ~~256~~312 of these rules, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56-135, Idaho Code. All audits related to fiscal years ending on or before December 31, 1999 are subject to rules in effect before July 1, 1999. ~~(7-1-97)~~(7-1-99)T

251. PRINCIPLE.

Providers of nursing home services will be paid at the allowed amount determined in accordance with Section 56-101 to 56-135~~1~~, Idaho Code. Total payment will be made up of the total of the following components: ~~(1-1-82)~~(7-1-99)T

01. Property And Utility Costs. All allowable property and utility costs; (9-15-84)

02. Nonproperty, Nonutility Costs. Nonproperty nonutility costs as determined in accordance with the above mentioned Sections of the Idaho Code. (9-15-84)

03. Efficiency Increment. An efficiency increment determined in accordance with the above mentioned Sections of the Idaho Code. (1-1-82)

04. Exempt Costs. Other allowable costs exempt from the percentile cap under Sections 56-110(b) and 56-117, Idaho Code, as specified in Subsection 254.08 and 254.09. (12-31-91)

252. PROPERTY AND UTILITY COSTS.

The allowability of each of these cost items will be determined in accordance with other provisions of this chapter, or the ~~HIM-15~~ PRM in those cases where this the rules of this chapter are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. ~~(7-1-97)~~(7-1-99)T

01. Depreciation. All allowable depreciation expense. (1-1-82)

02. Interest. All allowable interest expense relating to financing building and equipment purchases. Interest on working capital loans will be included as administrative costs. (1-1-82)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's

compensation and other employee-related insurances will not be considered to be property costs. (1-1-82)

04. Lease Payments. All allowable lease or rental payments. (1-1-82)

05. Property Taxes. All allowable property taxes. (1-1-82)

06. Utility Costs. All allowable expenses for heat, electricity, water and sewer. (9-15-84)

253. (RESERVED):

254. COSTS SUBJECT TO A CAP FOR NURSING FACILITIES.

Final reimbursement of these costs will be limited to the amount allowed as determined in accordance with Sections 56-101 through 56-135, Idaho Code. This Section defines items and procedures to be followed in determining this limit. Specifically, this Section provides the procedures for: (7-1-97)

01. Determining Costs. Extracting cost data from historical cost reports, cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the standard deviation of the range of costs and the percentile cap. (1-1-82)

02. Allowable Costs. Allowable costs to be included in this Section, as determined in accordance with this chapter or HIM-15, will be divided by the total patient days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid patients are not included on the total submitted costs for those services, the provider must determine the amount of those costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for the purpose of determining the percentile cap and for computing final reimbursement. (12-31-91)

03. Cost Data For Hospital Based Facilities. Cost data to be used to determine the percentile cap for facilities in the hospital facilities based class shall be taken from each provider's most recent twelve (12) month audit report finalized by the Department prior to ninety (90) days before the beginning of the period for which the percentile cap is being determined. (9-28-90)

04. Cost Data For Freestanding Nursing Facilities. Cost data to be used to determine the percentile cap for facilities in the Freestanding Nursing Facilities class shall be taken from each provider's most recent fiscal period closing cost report received by the Department prior to one hundred twenty (120) days before the beginning of the period for which the percentile cap is being determined. For cost reports covering a period of less than twelve (12) months the reports will be annualized for purposes of cost projections of Subsection 254.10 by extending the reporting period used to one (1) year from the beginning of the cost reporting period. (7-1-97)

05. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the table in Subsection 254.04.a. (12-31-91)

a. Cost Forecasting Market Basket:

Cost Category and Description	Forecaster
Payroll Expense—all wages and salaries excluding benefits	Average hourly earnings in nursing homes and personal care facilities homes
Employee Benefits	Skilled nursing facility employee benefits
Food—Wholesale Price Index	Processed foods and feeds component of the producers price index
Supplies—Include nursing, dietary, laundry, housekeeping and maintenance supplies	All Item Consumer Price Index

Cost Category and Description	Forecaster
Other Business Services - include dues, subscriptions, accounting and legal services, employee recruitment, telephone, office supplies and home office costs.	Service component of the Consumer Price Index
Fuel Oil and Coal	Fuel oil component of the Consumer Price Index
Electricity	Electricity component of the Consumer Price Index
Natural Gas	Utility gas component of the Consumer Price Index
Miscellaneous	All Item Consumer Price Index

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. (1-1-82)

06. Special Rates. Section 56-117, Idaho Code, provides for authority to the Director to pay facilities at special rates for care given to patients who have long term care needs beyond the normal scope of facility services. Patients with such needs who are otherwise unable to be placed in a nursing facility may include, but are not limited to, ventilator assisted patients, certain pediatric patients, certain comatose patients, and certain patients requiring nasogastric or intravenous feeding devices. In the event that the Director exercises this authority: (12-28-89)

a. A determination to approve or not approve a special rate will be made on a patient by patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid resource. (12-28-89)

b. A rate for each approved Medicaid patient will be set by the Department for extra costs the patient is expected to incur in excess of the cost of normal facility services. (12-28-89)

c. Costs equivalent to payments at the special rate will be removed from the category of costs subject to the percentile cap, will be reported separately, and will be fully reimbursed. (12-28-89)

d. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services. A provider's charges to non-Medicaid patients for similar needs beyond the normal scope of nursing facility services will be the maximum reimbursable amount related to the special rate. If the provider has no other patients who receive such services in the reporting period, the provider's published charges applicable to non-Medicaid patients for such needs will be the maximum reimbursable amount for the special rate. (12-28-89)

07. Costs Excluded From The Percentile Cap. For cost reports filed on or after July 1, 1989, identifiable increases in costs with an expected impact of two cents (\$.02) or more per patient day otherwise subject to the percentile cap incurred by facilities in the ICF/SNF Freestanding class as a result of changes in state or federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the percentile cap. (12-28-89)

a. A separate schedule or notations on the cost report are to be included so these excluded costs can be identified and so reported costs can be reconciled to the provider's general ledger. (12-28-89)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. (12-28-89)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department provides otherwise. (12-28-89)

d. For interim rate purposes the provider may be granted an increase in interim rates to cover such cost increases as allowed for in Section 303. A cost statement covering a recent period should be submitted with the justification for the increased costs. (12-31-91)

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at a time of its choosing, include all of the previously excluded costs related to those increases with costs subject to the percentile cap when setting rates. If a percentile cap is set with these particular costs included in the percentile cap category, providers subject to that percentile cap will not have these costs excluded from the percentile cap for interim rate or final settlement purposes. The intent of this provision is for costs to be exempt from the percentile cap until these costs are able to be fully and equitably incorporated in the data base used to set the percentile cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. (12-28-89)

f. When cost increases are to be excluded from the percentile cap and the effect of these cost increases would also be incorporated in the inflation indexes used to set the percentile cap, the cost indexes will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the percentile cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. (12-28-89)

08. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the cost reporting period from which they were derived to the midpoint of the period for which the reimbursement and the limitation of these costs is being calculated. Procedures for inflating these costs are as follows: (1-1-82)

a. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the period from which the per diem costs were derived. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint of the period from which the costs were derived to the end of that period. (1-1-82)

b. The percentage change for each cost category in the market basket will be computed for the period beginning at the end of the period from which the per diem costs were derived and ending at the beginning of the period for which the reimbursement and the limitation of these costs is being calculated. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 254.10.a. from the end of the period from which they were derived to the beginning of the period for which the reimbursement and the limitation is being determined. (12-31-91)

e. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the period for which the reimbursement and the limitation is being computed. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 254.10.b. from the beginning to the midpoint of the period for which the reimbursement and the limitation is being computed. (12-31-91)

09. Cost Ranking. Projected per diem costs as determined by Subsection 254.10 and subject to the percentile cap will be ranked from highest to lowest within each class of providers. Costs for providers will be grouped in classes according to the type of provider with the classes being Freestanding Nursing Facilities, Hospital Based Facilities, and ICF/MR. (12-31-91)

a. The standard deviation of the range will be computed based on the available data points being considered the total population of data points. (1-1-82)

b. The standard deviation figure will then be used to determine the percentile cap in accordance with the Idaho Code as follows:

If Two Times the Standard Deviation is	Then the Percentile Cap Will be
\$2.99 or less	100 percentile
\$3.00 to \$5.99	90 percentile

If Two Times the Standard Deviation is	Then the Percentile Cap Will be
\$6.00 to \$11.99	80 percentile
\$12.00 or greater	75 percentile

(1-1-82)

e. ~~The percentile cap will be computed based on the assumption that the range of costs is a statistically normal distribution unless the cap is to be at the one hundred (100) percentile. In that case, the highest cost in the range will become the percentile cap.~~ (1-1-82)

d. ~~The percentile cap for each facility's fiscal year following January 1, 1982, will be computed prior to the beginning of that fiscal year in accordance with the Idaho Code. For those facilities with a fiscal year ending on a date other than December 31, the first percentile cap will be computed for the period beginning January 1, 1981, and ending on their fiscal year end date.~~ (1-1-82)

e. ~~The percentile cap will be determined and set for each facility's upcoming fiscal year prior to that year and it will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical type errors, these errors will be corrected and the percentile cap adjusted to what it would compute to be using the corrected figures.~~ (1-1-82)

f. ~~Reimbursement of costs in this cost center will be limited to the percentile cap unless the provider can demonstrate to the Department of Health and Welfare that his facility was operated efficiently during the cost reporting period and that the costs incurred in excess of the percentile cap were beyond his control. In such case, costs in excess of the cap will be allowed to the extent that they are justified by this process.~~ (1-1-82)

g. ~~Facilities which for the first time offer patient care services in the hospital-based facilities class on or after April 1, 1985, shall be subject to the same limitation on nonproperty nonutility reimbursement as is applied to the freestanding nursing facilities class with the same fiscal year as the hospital based provider. The efficiency increment for such facilities shall be computed based on the fraction applicable to the freestanding nursing facilities class. Cost reports for such facilities shall be included in the hospital-based facilities class.~~ (9-28-90)

255. EFFICIENCY INCREMENT:

~~A nursing facility efficiency increment will be included as a component of the total reimbursement if the allowable per diem costs incurred by the nursing facility provider for those cost categories subject to the percentile cap addressed in Section 254, are less than percentile cap for the class in which the facility belongs.~~ (7-1-97)

01. Computing Efficiency Increment. ~~The efficiency increment will be computed by subtracting the actual allowable per diem costs incurred by the provider from the applicable percentile cap and multiplying the resultant figure by the fraction applicable to the cost center according to the following table:~~ (1-1-82)

EFFICIENCY INCREMENT	
Percentile Cap Applicable to The Class of Facilities	Fraction to be Used in Determining the Efficiency Increment
100 percentile	One-half (1/2)
90 percentile	One-third (1/3)
80 percentile	One-fourth (1/4)
75 percentile	One-sixth (1/6)

~~02. Allowable Increment.~~ The allowable increment cannot exceed one dollar and fifty cents (\$1.50) per Medicaid patient day. (1-1-82)

~~03. Determining Reimbursement.~~ Total reimbursement determined by adding amounts determined allowable in accordance with Sections 252, 253, 254, and 255, shall not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and HIM-15. In computing patient days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the patient is making payment for holding a bed in the facility, the patient will not be considered to be discharged and thus those days will be counted in the total. (12-31-91)

256. DEFINITIONS:

~~01. Lower Of Cost Or Charges.~~ In addition to 42 CFR Part 447, the Title XIX Medical Assistance Manual (MSA) PRG 1, Part 6-170-20B states that on cost related basis of reimbursement "... the limit on payments for extended care facilities (ECF's) under Title XVIII shall not exceed...". These limits are determined on an individual facility basis for comparable service. Supplement 5 of the 1972 amendments to the Providers Reimbursement Manual (SSA HIM-15) states "regulations based on the 1972 amendments (as revised by Section 16 of P.L. 93-233) state that for services rendered in cost reporting periods beginning after December 31, 1973, payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public shall be the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge shall be reimbursed fair compensation which is the same as reasonable cost." (1-16-80)

~~02. Customary Charges.~~ Customary charges are the regular rates for various services which are recorded for Medicare beneficiaries and charges to patients liable for such charges. Those charges are to be adjusted downward, however, where the provider does not impose such charges on most patients liable for payment on a charge basis or, fails to make reasonable collection efforts, the reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt (see Chapter 3, Sections 310 and 312, HIM-15). (1-16-80)

~~03. Public Provider.~~ A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (1-16-80)

~~04. Nominal Charges.~~ A public provider's charges are nominal where aggregate charges amount to less than one half (1/2) of the reasonable cost of the related services. The result of this is that the Title XIX rate may not exceed the Title XVIII rate, less ancillary charges or charges to third parties (i.e. general public) for comparable services. (1-16-80)

a. Assuming that the Title XVIII rate is ten dollars (\$10) per patient day (not including ancillaries), customary charges are fifteen dollars (\$15) per patient day. (12-31-91)

b. In this case the customary charges are in excess of the potential rate so they are not a limiting factor. However, the Title XVIII rate is less for equivalent services. Therefore, the interim reimbursement rate will be at the ICF/SNF rate of ten dollars (\$10) per patient day. (12-31-91)

~~2573. -- 299. (RESERVED).~~

(BREAK IN CONTINUITY OF SECTIONS)

300. RATE SETTING.

The objectives of the rate setting mechanism for nursing facilities are: (7-1-97)

~~01. Interim Payments.~~ To make payments to nursing facilities on an interim basis, which approximate as close as possible, the amount which will be received by the provider on final settlement through a prospective cost-based system which includes facility-specific case mix adjustments. (7-1-97)(7-1-99)T

02. Rate Adjustment. To set ~~interim~~ rates based on ~~projected cost data so that the rates will not need to be adjusted more than once per year except in cases where a provider experiences uncontrollable unanticipated cost increases~~ each facility's case mix index on a quarterly basis and establishing rates that reflect the case mix of that facility's Medicaid residents as of a certain date during the preceding quarter. ~~(1-1-82)(7-1-99)T~~

301. PRINCIPLE.

~~Interim~~ Reimbursement rates will be set based on projected cost data from cost reports and audit reports. Nursing facilities desiring a higher reimbursement rate may submit evidence to the Department substantiating their need for a higher rate and based on this evidence, adjustments may be made to the rate allowed. A provider may request a rate lower than his projected costs if he expects his costs to be less than projections show. Reimbursement is to be set for freestanding and hospital-based facilities. In general, the methodology will be a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. ~~(7-1-97) (7-1-99)T~~

302. DEVELOPMENT OF THE RATE.

Rates shall be rebased annually. Rate setting shall be prospective with new rates effective July 1 of each year. There will be no settlement between actual costs incurred during the rate year and the rate itself. Rates for skilled care nursing facilities with unaudited cost reports will be interim rates established by the Department until a rate is calculated based on an audited cost report. The draft audit of a cost report submitted by a facility shall be issued by the Department no later than five (5) months from the date all information required for completion of the audit is filed with the Department. Projected ~~d~~ data used to develop the ~~interim~~ reimbursement rate for nursing facilities will be made up of the following components: ~~(7-1-97)(7-1-99)T~~

01. Property Reimbursement. Per diem property costs as shown on the latest twelve (12) month cost report or audit report whichever is to be used in accordance with the cost reporting standards specified in Subsections 254.03.a. and 254.03.b. and the property rental rate as determined by Section 060, for facilities which receive this rate in lieu of property costs. No inflationary increase will be considered for property costs for the purpose of developing the interim rate. The property reimbursement component will be calculated in accordance with Section 060 of these rules. ~~(12-31-91)(7-1-99)T~~

02. Utility Costs. Projected utility costs for the facility's upcoming fiscal year may be submitted to the Department not less than ninety (90) days prior to the beginning date of the facility's upcoming fiscal year. In the absence of such submission the Department will project the facility's utility costs utilizing the methodologies found in Subsection 254.06. ~~(12-31-91)~~

03. Efficiency Increment. ~~An efficiency increment as determined in accordance with the provisions of Section 255.~~ Direct Care Component. The direct care component of a facility's rate is the lesser of the facility's inflated direct care per diem costs, or the case mix adjusted per diem cost limit for that type of provider (free-standing nursing facility and urban hospital-based facilities, or rural hospital-based facilities). The lesser of the cost or limitation is then case mix adjusted, based on the facility's Medicaid case mix index. ~~(12-31-91)(7-1-99)T~~

a. All costs included in the direct care component will be adjusted based on the facility's case mix indices, with the exception of raw food and Medicaid related ancillary costs. ~~(7-1-99)T~~

b. The direct care limitation will be adjusted based on each facility's case mix index. The calculated direct care limit will be divided by the statewide average facility-wide case mix index, and then multiplied by the individual facility-wide case mix index. ~~(7-1-99)T~~

c. The lesser of the cost or limit will be divided by the facility-wide case mix index, and then multiplied by the most recent quarterly Medicaid case mix index to arrive at the direct care component. ~~(7-1-99)T~~

04. Indirect Care Component. The indirect care component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider (freestanding nursing facilities and urban hospital-based facilities, or rural hospital-based facilities). ~~(7-1-99)T~~

05. Efficiency Incentive. The efficiency incentive is available to those providers, both freestanding and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type

of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by seventy percent (70%). There is no incentive available to those facilities with per diem costs in excess of the indirect care limit, or to any facility based on the direct care component. (7-1-99)T

046. Maximum Rate Calculated Reimbursement Rate. The reimbursement rate for a facility will be the sum of the Direct Care Component, Indirect Care Component, Efficiency Incentive, Cost Exempt from Limitation, and Property Reimbursement. In no case will the interim reimbursement rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is being made as computed in accordance with Section 256 by the lower of costs or customary charges. (42-31-91)(7-1-99)T

07. Cost Component. The cost component of each facility's rate shall be established effective July 1 of each year and remain in effect through the following June 30. The cost data used in establishing the cost component of the rate calculation will be from the audited or unaudited cost report which ended during the previous calendar year (i.e., cost reports ending during the period from January 1, 1998 - December 31, 1998 will be used in setting rates effective July 1, 1999). If unaudited data is used, the rate will be considered an interim rate until the audited data is available, at which time a retroactive adjustment to the payment rate will be made. (7-1-99)T

08. Case Mix Component. The Medicaid case mix indices used in establishing each facility's rate will be recalculated quarterly and each facility's rate will be adjusted accordingly. The case mix indices will be calculated based on the most recent assessment for each resident in the facility on the first day of the second month of the preceding quarter (i.e., assessments as of May 1, 1999 would be used to establish the case mix indices needed to establish rates for the quarter beginning July 1, 1999). (7-1-99)T

303. CHANGES TO THE NURSING FACILITY RATE COST LIMITS.

Effective July 1, 1999, and each July 1 thereafter, cost limitations shall be established for nursing facilities based on the most recent audited cost report with an end date of June 30 of the previous year or before. Calculated limitations shall be effective for a one (1) year period, from July 1 through June 30 of each year. (7-1-99)T

01. Rate Waiver. A nursing facility provider desiring a higher interim rate than that rate determined in accordance with Section 302, may submit to the Department evidence and documentation substantiating the rate being requested. The Department will review this information and if it adequately documents the need for a higher rate, the rate will be adjusted upward. **Percentage Above Bed-Weighted Median.** Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999 through June 30, 2000 will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 300 through 302 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Once established, these percentages will remain in effect for future rate setting periods. (7-1-97)(7-1-99)T

02. Lower Rate. If a provider desires a lower rate than that rate determined in accordance with Section 302, in order to avoid being overpaid when final settlement for the period is being computed, he may request a lower rate. The lower rate will be set at the level desired by the provider. **Direct Cost Limits.** The direct cost limitation shall be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (42-31-91)(7-1-99)T

03. Frequency. The interim rate as determined in accordance with this Section will be set for each provider's upcoming fiscal year. The rate may be adjusted a maximum of two (2) times per year at the initiation of either the Department or the provider; however, an adjustment will only be made in those cases where it can be shown

~~that:~~ **Indirect Cost Limits.** The indirect cost limitation shall be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. ~~(1-1-82)(7-1-99)T~~

~~and-~~ a. Cost increases or decreases were unforeseen and not compensated for by the inflation indices used; ~~(1-1-82)~~

b. In the case of cost increases, changes were outside the control of the provider. ~~(1-1-82)~~

04. Limitation On Increase Or Decrease Of Cost Limits. Increases in the direct and indirect cost limits shall be determined by the limitations calculated effective July 1, 1999, indexed forward each year by the inflation factor plus two percent (2%) per annum. Furthermore, the calculated direct and indirect cost limits shall not be allowed to decrease below the established limitations effective July 1, 1999. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee after a three-year period to determine which factors to use in the calculation of the limitations effective July 1, 2002 and forward.

~~(7-1-99)T~~

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 123.

~~(7-1-99)T~~

304. TREATMENT OF NEW BEDS.

Facilities which add beds subsequent to the effective date of these rules (July 1, 1999), will have their reimbursement rate subjected to an additional limitation for the next three (3) full years. This limitation will apply beginning with the first rate setting period which utilizes a cost report that includes the date when the beds were added. The facility's rate will be limited to the bed-weighted average of two (2) rates. Those two (2) rates are:

~~(7-1-99)T~~

01. Limitation Of Facilities Rate. The facility's rate will be limited to the bed-weighted average of the facility's rate calculated in accordance with Section 302, and the current median rate for skilled care facilities of that type (freestanding or hospital-based) established each July 1.

~~(7-1-99)T~~

02. Calculation Of New Bed Rate. The current calculated facility rate will be multiplied by the number of beds in existence prior to the addition. The median rate will be multiplied by the number of added beds (weighted for the number of days in the cost reporting period for which they were in service). These two (2) amounts will be added together and divided by the total number of beds (with the new beds being weighted if they were only in service for a portion of the year). The resulting per diem will represent an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation will receive their calculated rate.

~~(7-1-99)T~~

03. Exception To New Bed Rate. Any beds converted from nursing facility to assisted living beds may not be reclassified to new nursing facility beds until three (3) years have elapsed from the date the beds were reclassified to assisted living beds.

~~(7-1-99)T~~

305. TREATMENT OF NEW FACILITIES.

Facilities constructed subsequent to July 1, 1999, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation. During the period of limitation, the facility's rate will be modified each July 1 to reflect the current median rate for skilled care facilities of that type. After the first three (3) full years, the facility will have its rate established at the next July 1 with the existing facilities in accordance with Section 302 of this rule.

~~(7-1-99)T~~

306. TREATMENT OF A CHANGE IN OWNERSHIP.

New providers resulting from a change in ownership of an existing facility shall receive the previous owner's rate until such time as the new owner has a cost report which qualifies for the rate setting criteria established under these rules.

~~(7-1-99)T~~

307. DISTRESSED FACILITY.

If the Department determines that a facility is operationally or financially unstable, is located in an under-served area, or addresses an under-served need, the Department may negotiate a reimbursement rate different than the rate then in effect for that facility. (7-1-99)T

308. INTERIM ADJUSTMENTS TO RATES AS A RESULT OF NEW MANDATES.

Certain costs may be excluded from the cost limit calculations, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rates as provided in this Section to assure equitable reimbursement: (7-1-99)T

01. Changes Of More Than Fifty Cents Per Patient Day In Costs. Changes of more than fifty cents (\$.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. (7-1-99)T

a The provider shall report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. (7-1-99)T

b If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately. (7-1-99)T

c The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-99)T

02. Interim Rate Adjustments. For interim rate purposes, the provider may be granted an increase in its prospective rate to cover such cost increases. A cost statement covering a recent period may be required with justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-99)T

03. Future Treatment Of Costs. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed. (7-1-99)T

309. MDS REVIEWS.

The following Minimum Data Set reviews will be conducted: (7-1-99)T

01. Facility Review. Subsequent to the picture date, each facility will be sent a copy of its resident roster (a listing of residents, their RUG classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review. (7-1-99)T

02. Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data. (7-1-99)T

310. SPECIAL RATES.

Section 56-117, Idaho Code, provides authority for the Director to pay facilities a special rate for care given to patients who have long term care needs beyond the normal scope of facility services. These patients must have needs which are not adequately reflected in the rates calculated pursuant to the principles set forth in Section 56-102, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of this section will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. (7-1-99)T

01. Determinations. A determination to approve or not approve a special rate will be made on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. (7-1-99)T

02. Application. Until the facility applies for a special rate, patients with such needs will be included in the computation of the facility's rates following the principles described in Section 56-102, Idaho Code. (7-1-99)T

03. Approval. Approved special rates will become effective on the date the application is received, but no earlier than the first day of the month in which the application for a special rate was received. (7-1-99)T

04. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (7-1-99)T

05. Limitation. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services. (7-1-99)T

311. PHASE-IN PROVISIONS.

The rates established pursuant to these rules shall be phased in over a three-year period as follows: (7-1-99)T

01. July 1, 1999 Through December 31, 1999. During this period, providers will continue to be reimbursed under the previous retrospective system; however, the Department will also issue by July 1, 1999 and October 1, 1999, "shadow rates" which will inform facilities what their rate would be under the provisions of these rules. (7-1-99)T

02. January 1, 2000 Through June 30, 2000. Rates calculated under the provisions of these rules will be compared to the rates that were available to the same facility as of June 30, 1999. Facilities which would experience decreases in their rate of one dollar (\$1) or less per resident day will receive the rate established under the provisions of these rules with no phase-in. Facilities which would experience decreases in their rate of greater than one dollar (\$1) per resident day will have the decrease in their rate limited to the greater of one dollar (\$1) per resident day or twenty-five percent (25%) of the decrease. Facilities which would experience increases in their reimbursement rate will receive the increased rate. (7-1-99)T

03. July 1, 2000 Through June 30, 2001. Rates calculated under the provisions of these rules will be compared to the rates that were available to the same facility as of June 30, 1999. Facilities which would experience decreases in their rate of two dollars (\$2) or less per resident day will receive the rate established under the provisions of these rules with no phase-in. Facilities which would experience decreases in their rate of greater than two dollars (\$2) per resident day will have the decrease in their rate limited to the greater of two dollars (\$2) per resident day or fifty percent (50%) of the decrease. Facilities which would experience increases in their reimbursement rate will receive the increased rate. (7-1-99)T

04. July 1, 2001. Beginning with July 1, 2001, the rates established under the provisions of these rules will be fully implemented with no phase-in. (7-1-99)T

312. OVERSIGHT COMMITTEE.

The Director will appoint an oversight committee to monitor implementation of the Prospective Payment System (PPS) for nursing facility reimbursement that takes effect July 1, 1999. The committee will be made up of at least one (1) member representing each of the following organizations: the Department, the state association(s) representing

free standing skilled care facilities, and the state association(s) representing hospital-based skilled care facilities. The committee will continue to meet periodically subsequent to the implementation of the PPS. After three (3) years of implementation, the committee will examine the inflation factors used to inflate costs forward for rate setting (DRI + one percent (+1%), the inflation factors used in limiting the growth in the cost component limitations (DRI + two percent (+2%)), and the level of the minimum cost component limitations (not lower than limits established July 1, 1999). (7-1-99)T

30413. DISPUTES.

01. Administrative Review Requirement. If any facility wishes to contest the way in which a rule or contract provision relating to the prospective, cost-related reimbursement system was applied to such facility by the Director, it shall first pursue the administrative review process set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 300, et seq., and Section 301, "Rules Governing Contested Cases and Declaratory Rulings". (12-31-91)

02. Legal Challenge. The administrative review process need not be exhausted if a facility wishes to challenge the legal validity of a statute, rule, or contract provision. (12-31-91)

305. (RESERVED).

30614. DENIAL, SUSPENSION, REVOCATION OF LICENSE OR PROVISIONAL LICENSE -- PENALTY.

The Director is authorized to deny, suspend, or revoke a license or provisional license or, in lieu thereof or in addition thereto, assess monetary penalties of a civil nature not to exceed one thousand dollars (\$1000) per violation in any case in which it finds that the facility, or any partner, officer, director, owner of five percent (5%) or more of the assets of the facility, or managing employee: (12-31-91)

01. Failed Or Refused To Comply. Failed or refused to comply with the requirements of Sections 56-101 through 56-135, Idaho Code, or the rules established hereunder; or (1-1-82)

02. False Statements. Has knowingly or with reason to know made a false statement of a material fact in any record required by this chapter; or (1-1-82)

03. Refused To Allow Representative. Refused to allow representatives or agents of the Director to inspect all books, records, and files required to be maintained by the provisions of this chapter or to inspect any portion of the facility's premises; or (1-1-82)

04. Wilfully Prevented, Interfered With, Or Attempted To Impede Work. Wilfully prevented, interfered with, or attempted to impede in any way the work of any duly authorized representative of the Director and the lawful enforcement of any provision of this chapter; or (1-1-82)

05. Preservation Of Evidence. Wilfully prevented or interfered with any representative of the Director in the preservation of evidence of any violation of any of the provisions of this chapter. (12-31-91)

30715. -- 349. (RESERVED).

350. AUDITS.

The objectives of an audit are: (1-16-80)

01. Accuracy Of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (1-16-80)

02. Reliability Of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results to the provider's operations. (1-16-80)

03. Economy And Efficiency. To determine if Title XIX recipients have received the required care on a basis of economy and efficiency. (1-16-80)

04. Application Of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (1-16-80)

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding his fiduciary responsibilities for patients, funds and property. (1-16-80)

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (1-16-80)

07. Compliance. To provide recommendations which will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program recipients. (1-16-80)

08. Final Settlement. To effect final settlement when required by Sections 250 through 350 of this rule. (~~1-16-80~~)(7-1-99)T

(BREAK IN CONTINUITY OF SECTIONS)

~~353. DEFINITIONS.~~

~~**01. Limited Scope Audits.** Limited scope audits are designed as information gathering tools. Normally, such audits will only include examination of a few accounts, practices or policies. (1-16-80)~~

~~**02. Full Scope Audits.** Full scope audits are intended to be extensive. These audits will include an examination of all financial records, provider policies, etc., considered necessary to the audit objectives. (1-16-80)~~

~~354. STANDARDS AND REQUIREMENTS.~~

01. Review Of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (1-16-80)

02. Requirements. Section 2404.3 of the August, 1973 revision of the Providers Reimbursement Manual (~~SSA-HM-15 PRM~~) states: "Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary." (~~1-16-80~~)(7-1-99)T

03. Examination Of Records. Examination of records and documents may include, but not be limited to: (1-16-80)

a. Corporate charters or other documents of ownership including those of a parent or related companies. (1-16-80)

b. Minutes and memos of the governing body including committees and its agents. (1-16-80)

c. All contracts. (1-16-80)

d. Tax returns and records, including workpapers and other supporting documentation. (1-16-80)

e. All insurance contracts and policies including riders and attachments. (1-16-80)

f. Leases. (1-16-80)

- g. Fixed asset records (see audit section - Capitalization of Assets). (1-16-80)
- h. Schedules of patient charges. (1-16-80)
- i. Notes, bonds and other evidences of liability. (1-16-80)
- j. Capital expenditure records. (1-16-80)
- k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (1-16-80)
- l. Evidence of litigations the facility and its owners are involved in. (1-16-80)
- m. Documents of ownership including attachments which describe the property. (1-16-80)
- n. All invoices, statements and claims. (1-16-80)
- o. "Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit workpapers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request." (~~SSA-HM-15-PRM~~, paragraph 2404.4(Q) of the Providers Reimbursement Manual) (~~1-16-80~~)(7-1-99)T
- p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (1-16-80)
- q. All patient records, including trust funds and property. (1-16-80)
- r. Time studies and other cost determining information. (1-16-80)
- s. All other sources of information needed to form an audit opinion. (1-16-80)
- 04. Adequate Documentation.** (1-16-80)
 - a. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited (~~SSA-HM-15-PRM~~, Section 2304). (~~1-16-80~~)(7-1-99)T
 - b. Expenses. Adequate documentation would normally include: an invoice, or a statement with invoices attached which support the statement. All invoices should meet the following standards: (1-16-80)
 - i. Date of service or sale; (1-16-80)
 - ii. Terms and discounts; (1-16-80)
 - iii. Quantity; (1-16-80)
 - iv. Price; (1-16-80)
 - v. Vendor name and address; (1-16-80)
 - vi. Delivery address if applicable; (1-16-80)
 - vii. Contract or agreement references; and (1-16-80)
 - viii. Description, including quantity, sizes, specifications brand name, services performed, etc.;

(1-16-80)

c. Capitalization of Assets. Major movable equipment shall be capitalized. Minor movable equipment shall not be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset (~~SSA-HM-15 PRM~~, Section 108.1). This rule shall apply except as to the provisions of Section 106 of ~~HM-15 PRM~~ for small tools, etc. ~~(+1-4-85)(7-1-99)T~~

i. Completed depreciation records must meet the following criteria for each asset: (1-16-80)

(1) Description of the asset including serial number, make, model, accessories, and location. (1-16-80)

(2) Cost basis should be supported by invoices for purchase, installation, etc. (1-16-80)

(3) Estimated useful life. (1-16-80)

(4) Depreciation method such as straight line, double declining balance, etc. (1-16-80)

(5) Salvage value. (1-16-80)

(6) Method of recording depreciation on a basis consistent with accounting policies. (1-16-80)

(7) Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (1-16-80)

(8) Reported depreciation expense for the year and accumulated depreciation shall tie to the asset ledger. (1-16-80)

ii. Depreciation Methods and Lives. (12-31-91)

(1) Methods. Straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (4-28-89)

(2) Depreciable Lives. The life of any asset may not be shorter than ~~the American Hospital Association the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 1993 revised edition Guidelines Lives, which is hereby incorporated by reference into these rules.~~ Deviation from these guidelines will be allowable only upon authorization from the ~~Department, Office of Audit or its successor organization.~~ A copy of this document may be obtained from the American Hospital Association Guidelines is included in Section 401 American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. Where guidelines do not provide a materially similar life for technical equipment, AHA guidelines will be used. ~~(7-1-97)(7-1-99)T~~

iii. Lease Purchase Agreements. Lease purchase agreements may generally be recognized by the following characteristics: (1-16-80)

(1) Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (4-28-89)

(2) Intent to create security interest; (1-16-80)

(3) Lessee may acquire title through exercise of purchase option which requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (1-16-80)

(4) Noncancellable or cancellable only upon occurrence of a remote contingency; and (1-16-80)

(5) Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (1-16-80)

iv. Assets acquired under such agreements will be viewed as contractual purchases and treated

accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (12-31-91)

- d. Personnel. Complete personnel records normally contain the following: (1-16-80)
 - i. Application for employment. (1-16-80)
 - ii W-4 Form. (1-16-80)
 - iii. Authorization for other deductions such as insurance, credit union, etc. (1-16-80)
 - iv. Routine evaluations. (1-16-80)
 - v. Pay raise authorization. (1-16-80)
 - vi. Statement of understanding of policies, procedures, etc. (1-16-80)
 - vii. Fidelity bond application (where applicable). (1-16-80)
- 05. Internal Control.** (1-16-80)
 - a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (1-16-80)
 - i. Safeguarding assets and resources against waste, fraud, and inefficiency. (1-16-80)
 - ii. Promoting accuracy and reliability in financial records. (1-16-80)
 - iii. Encouraging and measuring compliance with company policy and legal requirements. (1-16-80)
 - iv. Determining the degree of efficiency related to various aspects of operations. (1-16-80)
 - b. An adequate system of internal control over cash disbursements would normally include: (1-16-80)
 - i. Payment on invoices only, or statements supported by invoices. (1-16-80)
 - ii. Authorization for purchase such as a purchase order. (1-16-80)
 - iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (1-16-80)
 - iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (1-16-80)
 - v. Check of invoice accuracy. (1-16-80)
 - vi. Approval policy for invoices. (1-16-80)
 - vii. Method of invoice cancellation to prevent duplicating payment. (1-16-80)
 - viii. Adequate separation of duties between ordering, recording, and paying. (1-16-80)
 - ix. System separation of duties between ordering, recording, and paying. (1-16-80)
 - x. Signature policy. (1-16-80)
 - xi. Prenumbered checks. (1-16-80)
 - xii. Statement of policy regarding cash or check expenditures. (1-16-80)

- xiii. Adequate internal control over the recording of transactions in the books of record. (1-16-80)
- xiv. An imprest system for petty cash. (1-16-80)
- 06. Accounting Practices.** Sound accounting practices normally include the following: (1-16-80)
 - a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (1-16-80)
 - b. Chart of accounts. (1-16-80)
 - c. A budget or operating plan. (1-16-80)

3554. PATIENT FUNDS.

The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (1-16-80)

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (1-16-80)

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (1-16-80)

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (1-16-80)

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or his agent in writing. (9-1-85)

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (1-16-80)

03. Fund Management. Proper management of such funds would include the following as minimum: (1-16-80)

- a. Savings accounts, maintained separately from facility funds. (1-16-80)
- b. An accurate system of supporting receipts and disbursements to patients. (1-16-80)
- c. Written authorization for all deductions. (1-16-80)
- d. Signature verification. (1-16-80)
- e. Deposit of all receipts of the same day as received. (1-16-80)
- f. Minimal funds kept in the facility. (1-16-80)
- g. As a minimum these funds must be kept locked at all times. (1-16-80)
- h. Statement of policy regarding patient's funds and property. (1-16-80)
- i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (1-16-80)

j. System of periodic review and correction of policies and financial records of patient property and funds. (1-16-80)

3565. DRUGS.

The rules governing payment for prescription drugs to outpatients are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, Sections 126 through Subsection 090.01, "Rules Governing Medical Assistance". (12-31-91)

01. Nonlegend Drugs. (7-1-93)

a. For providers which have no pharmacy on the premises, reimbursement will be available for nonlegend drugs subject to a test of reasonableness related to the market place and must not exceed the pharmacist's charges to private pay patients. This means that charges to the patient may not exceed the billing to the provider including, but not limited to, adjustments by discounts or terms. (9-1-85)

b. For providers who have a pharmacy on the premises, reimbursement will be available for nonlegend drugs at cost plus a dispensing fee established by the ~~Bureau~~ Division of Medicaid ~~Policy~~. (~~12-31-91~~)(7-1-99)T

02. Record-Keeping Requirements. According to requirements in the Providers Reimbursement Manual ~~HM-15~~ PRM, Section 2104, the provider, as part of its financial record keeping responsibility under the program, must have on supplier invoices all needed cost verification information including name brand, quantity, form and strength of the drugs supplied and the provider's actual cost. In the absence of such information and in accordance with Section 1815 of the Social Security Act and Section 405.453 of the regulations, the Department must deny charges for unlabeled drugs because of inadequate records. Any cost reductions received on drug purchases including, but not limited to, discounts (cash, trade, purchase and quantity), or rebates, must also be clearly reflected on the individual invoices or related documentation. (~~1-16-80~~)(7-1-99)T

3576. ACCOUNTING TREATMENT.

Generally accepted accounting principles, concepts, and definitions shall be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be that one which most clearly attains program objectives. (1-16-80)

01. Final Payment. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. In addition, an efficiency incentive will be allowed to low cost providers in accordance with the provisions of Section 255. (12-31-91)

02. Overpayments. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. (1-16-80)

03. Other Actions. Generally overpayment shall result in two (2) circumstances: (1-16-80)

a. If the cost report is not filed the sum of the following shall be due: (1-16-80)

i. All payments included in the period covered by the missing report(s). (1-16-80)

ii. All subsequent payments. (1-16-80)

b. Excessive reimbursement or noncovered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction shall be designated to effect at least one of the following: (1-16-80)

i. Discontinuance of overpayments (on an interim basis). (1-16-80)

ii. Recovery of overpayments. (1-16-80)

358. NOTICE OF PROGRAM REIMBURSEMENT-

Following receipt of the interim final audit report from the Office of Audit, the Bureau of Medicaid Policy or its successor agency will review that report to assure appropriate consistency of the audit with methods and elements used in setting interim rates; current rules; current policies and rule interpretations; the treatment of other providers; and other considerations necessary to finalize the audit. In the event that the Bureau of Medicaid Policy desires further documentation from the provider in order to finalize the audit, the provider will be allowed not less than thirty (30) days in which to submit such documentation. Thereafter a final audit report and a certified letter, setting forth the amounts of underpayment or overpayment made to the provider, with a return receipt requested, will be sent to the provider. The certified letter is the notice of program reimbursement. Where the determination in the notice shows that the provider is indebted to the Department because total interim and other payments exceed allowed reimbursement, the Department will take the necessary action to recover overpayments, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an administrative review or hearing is filed pursuant to provisions of Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 330, "Rules Governing Contested Cases and Declaratory Rulings," if the review or hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (12-31-91)

359. INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS TO PROVIDERS-

The Department will charge interest on overpayments and pay interest on underpayments to providers as follows:

(4-28-89)

01. Interest After Sixty (60) Days Of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement as defined in Section 358, and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. (12-31-91)

02. Waiver Of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting exceeds the charges. (4-28-89)

03. Rate Of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104, Idaho Code, compounded monthly. (4-28-89)

04. Retroactive Adjustment. The balance and interest shall be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative review and judicial appeal process. Interest penalties shall only be applied to unpaid amounts and shall be subordinated to final interest determinations made in the judicial review process. (4-28-89)

360. RECOVERY METHODS-

Recovery following notice of program reimbursement shall be effected by one (1) of the following methods:

(4-28-89)

01. Lump Sum Voluntary Repayment. Pursuant to the provider's receipt of the notice of program reimbursement, the provider refunds the entire overpayment to the Department. (4-28-89)

02. Periodic Voluntary Repayment. The provider may request in writing that recovery of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested. The request must be made within thirty (30) days of receipt of the notice of program reimbursement. (4-28-89)

03. Department Initiated Recovery. The Department shall recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receipt. (4-28-89)

~~04. Recovery From Medicare Payments.~~ The Department may request that Medicare payments be withheld in accordance with 42 CFR, Subpart C, Section 405.375. (4-28-89)

~~05. Other Actions For Recovery.~~ If the Department cannot make recovery by the above methods it may initiate action to recover amounts due from the provider by making recovery from other facilities or entities owned, operated or otherwise related to the provider or by taking action to collect directly from the owner or owners of the facility. (4-28-89)

~~361-57.~~ -- 399. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

~~401. AMERICAN HOSPITAL ASSOCIATION GUIDELINE LIVES (RESERVED).~~

~~01. Estimated Useful Life Of Land Improvements, Buildings, And Fixed Equipment. (7-1-93)~~

LAND IMPROVEMENTS	YEARS
Fencing Brick or stone	25
Chain link	15
Wire	5
Wood	8
Flagpole	20
Paving (including roadways, walks, and parking) Asphalt	15
Concrete	20
Gravel	5
Retaining wall	20
Shrubs, lawns, and trees	10
Sign	12
Turf, artificial	5
Underground sewer and water lines	30
Yard lighting	15
BUILDINGS	YEARS
Boiler house	15-25
Garage Masonry	25
Wood frame	15
Masonry, reinforced concrete frame.	25-30
Masonry, steel frame, fireproofed	25-30
Masonry, steel frame, not fireproofed	20-25
Masonry, wood frame	20-25

Multilevel parking structure, masonry	20-25
Residence Masonry	20-25
Wood frame	15-20
Storage building	20
FIXED EQUIPMENT – BUILDING SERVICES	YEARS
Central clock system	20
Central television antenna system	15
Electric lighting and power feed wiring	20
Conduit and wiring	20
Fixtures	20
Switch gear	20
Transformer	20
Elevator Dumbwaiter	20
Freight	20
Passenger, high-speed automatic	20
Passenger, other	20
Heating/ventilating/air conditioning system	20
Air conditioning system, all equipment and units- Large – over 20 tons	15
Medium - 5 to 15 tons	10
Small – under 5 tons	8
Boiler	20
Compressor, air	15
Condensate tank	10
Condenser	15
Controls	15
Cooler and dehumidifier	10
Cooling tower Metal	15
Wood	15
Duct work	20
Fan, air handling and ventilating.	15
Filter	15
Furnace, domestic type	15
Incinerator, indoor	10
Oil storage tank	20
Piping	20

Precipitator	10
Pump	10
Radiator, cast iron	25
Radiator, finned tube	15
Unit heater	10
Nurse call system	15
Oxygen, gas, air piping	20
Paging system	15
Plumbing composite	20
Fixtures	20
Piping	25
Pump	15
Water heater, commercial	15
Water storage tank	20
Sprinkler and fire protection system	25
Fire alarm system	15
Fire pump	20
Smoke and heat detectors	10
Sprinkler system	25
Tank and Tower	25
Sewerage, composite	25
Piping	20
Sump pump and sewerage ejector	10
Telephone system	10
Vacuum cleaning system	15
OTHER FIXED EQUIPMENT	YEARS
Built-in bench/bin/cabinet counter/shelving	20
Carpentry work	15
Carpeting	5
Conveying system	15
Generator set	20
Hood, fume	15
Sink and drainboard	20
Sterilizer, built-in	15

02. ~~Estimated Useful Life Of Individual Items Of Major Movable Equipment.~~

(7-1-93)

ITEM	YEARS
Accelerator	7
Accounting/bookkeeping machine	5
Adding machine	5
Air conditioner (window)	5
Ambulance	4
Amplifier	10
Analyzer, gas	10
Analyzer, oxygen	10
Anesthesia unit	10
Ankle exerciser	15
Apparatus Anesthesia	12
Resuscitating	10
Blood transfusion	15
Bone surgery	10
Aspirator	10
Audiometer	10
Autoclave	20
Automobile, delivery	4
Automobile, passenger	4
Autosealer, ionic	10
Balance	7
Basal metabolism unit	8
Bassinet	15
Bassinet, heated	10
Bath, paraffin	10
Bath, serological	10
Bath, water, laboratory	10
Bed, electric	15
Bed, manual	15
Bench, metal or wood	15
Bin, metal or wood	20
Biochemical analysis unit, micro	8

ITEM	YEARS
Blanket drier	15
Blanket warmer	15
Bleach tank	15
Block, butcher or meat	10
Blood chemistry analyzer, automated	8
Blood cell counter	5
Blood gas analyzer	8
Blood gas apparatus, volumetric	8
Blood warmer	10
Blood warmer coil	8
Boiler, copper	20
Bookcase, metal	20
Bottle washer	10
Breathing unit, positive pressure	8
Broiler	10
Buffer, electric	5
Bulletin Board	10
Burnisher silverware	15
Cabinet, bedside	15
Cabinet, metal or wood	15
Cabinet, solution	15
Calculator	5
Camera	5
Camera/TV monitoring/color/black & white	5
Camera/videotape/color/black & white	5
Canopy, ventilating, ironer	15
Capsule machine	10
Cardioscope	8
Carpeting	5
Cart, food/tray, heat refrig	10
Cash register	5
Cassette changer	8
Cautery unit	10
Central processing unit	10

ITEM	YEARS
Centrifuge	10
Chair, dental	15
Chair, executive	15
Chair, metal or wood	10
Chair, specialist	15
Chair, wheel	5
Chart rack	20
Check signer	10
Chromatograph, gas	10
Clock	10
Clothes locker, fiberglass or metal	20
Clothes locker, laminate or wood	12
Cobalt unit	8
Coffee grinder	10
Cold pack unit, floor	10
Collator, electric	10
Collector, silver, automatic	8
Colorimeter	8
Compactor, waste	10
Compressor, air	12
Conductivity tester	5
Conveyer, tray	10
Conveying system, laundry	10
Cooker, pressure, food	10
Cooker, starch	20
Cooler, walk-in, freestanding	15
Cooler, water	10
Counter, food service	15
Croupette	10
Crusher, syringe	10
Cryosurgical unit	10
Cryostat	10
Curtain stretcher	15
Cutter, cloth, electric	10

ITEM	YEARS
Cutter, food	10
Cystometer	10
Cystoscooper	10
Dampener	15
Data card processing unit including keypunch, verifier, reader, sorter	10
Data printing unit	5
Data storage unit, mechanical	10
Data storage unit, nonmechanical	15
Data tape processing unit including controller, drive, tape deck	5
Decalcifier	10
Defibrillator	8
Densitometer, recording	8
Dermatome	10
Desk, metal or wood	15
Diathermal apparatus	10
Diathermy unit	10
Dictating equipment	5
Dilutor	10
Dish sterilizer	10
Dishwasher	10
Disinfecter	10
Dispenser, alcohol	10
Dispenser, butter, refrigerated	10
Dispenser, milk or cream	10
Distilling apparatus	15
Dresser	15
Drill press	20
Dryer, clothes	10
Dryer, hair	5
Dryer, sonie	10
Drying oven, paint shop	10
Duplicator	5
Electrocardiograph	7
Electrocephalograph	7

ITEM	YEARS
Electromyograph	7
Electrophoresis unit	8
Electrosurgical unit	8
Ether-suction unit	10
Evacuator	10
Exercise apparatus	15
Extractor, fruit juice	10
Extractor, laundry	15
Fire extinguisher	20
Floor scrubbing machine	5
Floor waxing machine	5
Flowmeter	10
Fluorimeter	10
Fluoroscope	8
Folder, flatwork	15
Food chopper	10
Frame, turning	15
Fryer, deep fat	10
Furnace, laboratory	10
Glove conditioner	10
Glove dryer	10
Glove powdering machine	10
Glove tester	10
Graphotype	15
Griddle	10
Grinder, bench	10
Grinder, food waste	10
Hamper	5
Heart-lung system	8
Hemoglobinometer	10
Hemodialysis unit	5
Homogenizer	10
Hot plate	5
Humidifier	10

ITEM	YEARS
Hydrotherapy equipment	15
Hyfreecator	10
Hypothermia apparatus	10
Ice cream freezer	10
Ice cream storage cabinet	10
Ice cube making equipment	10
Illuminator unit, multifilm	15
Illuminator unit, single	15
Imprinter, embossed plant	10
Incubator, laboratory	10
Incubator, nursery	10
Indicator, remote	10
Infusion pump	10
Inhalator	10
Intereom	10
Ironer, flatwork	15
Ironing board	15
Isotope equipment	8
Jointer/planner, electric	20
Kettle, steam jacketed	15
Kickbucket	10
Kidney dialyzer	5
Kiln	15
Kymograph	10
Ladder	10
Lamp, deep therapy	10
Lamp, emergency	10
Lamp, infrared	10
Lamp, mercury quartz	10
Lamp microscope	10
Laryngoscope	10
Lathe	15
Lawn mower, power	3
Library furnishings	20

ITEM	YEARS
Lifter, patient	10
Light, delivery	15
Light, examining	10
Light, operating	15
Light, portable, emergency	10
Linen cart	10
Linen dryer	15
Linen marker	15
Linen press	15
Linen table	15
Linen washer	15
Mailing machine	10
Mannequin	10
Marking machine	15
Mattress	8
Meat chopper	10
Meter, pH	10
Microfilm unit	10
Microscope	10
Microprojector	15
Microtome	10
Mixer, commercial type	10
Model, anatomical	10
Monitor, TV	5
Mop truck	10
Narcotic safe	25
Nebulizer	10
Operating stool	15
Ophthalmoscope	10
Oscilloscope	7
Osometer	10
Otoscope	10
Ottoman	10
Oven, baking	10

ITEM	YEARS
Oven, microwave	5
Oven, paraffin	10
Oven, roasting	10
Oven, sterilizing	10
Oximeter	10
Oxygen tank, motor, and truck	8
Pacemaker, cardiac	5
Paint spray booth	15
Paint spraying machine	10
Paper baler	15
Parallel bars	15
Patient monitoring equipment	7
Peeler, vegetable, electric	10
Photocoagulator	10
Photocopier	5
Photography apparatus, gross pathology	10
Photometer	8
Physician's in and out register/portable	10
Piano	20
Pipette, automatic	10
Planer and shaper, electric	10
Polisher, floor	5
Polishing and buffing machine	5
Power supply	10
Press, laundry	15
Proctoscope	5
Projection machine	10
Projector, slide	10
Prothrombin timer, automated	10
Pulmonary function equipment	10
Pump, vacuum or pressure	10
Rack, pot or pan	20
Radiation counter	8
Radiation meter	8

ITEM	YEARS
Radigraphic-fluoroscopic combination	8
Radioactive source, cobalt	5
Range, household	10
Recorder, laboratory	10
Refractometer	10
Refrigerator, blood bank	10
Refrigerator, commercial or domestic type	10
Remote control receiver	10
Resuscitator	10
Rinser, sonic	10
Safe	20
Sanitizer	10
Saw, autopsy	10
Saw, bench, electric	20
Saw, neurosurgery	10
Saw, surgical, electric	10
Scale, laundry, movable	10
Scale, laundry, platform	15
Scale, postal	10
Scanner, isotope	8
Scintillation scaler	8
Seriograph, automatic	10
Sewing machine	15
Shaking machine	10
Sharpener, microtome knife	12
Shears, squaring, floor	12
Shelving, portable, steel	20
Shoulder wheel	20
Sigmoidoscope	5
Skeleton	10
Slicer, bread	10
Slicer, meat	10
Slide stainer, laboratory	10
Slit lamp	10

ITEM	YEARS
Snow-blower	5
Soap dispenser	10
Spectroscope	10
Spectrophotometer	8
Sphygmomanometer	10
Stall bars	20
Stamp machine	10
Stand, irrigating	15
Stapler, electric or air	10
Steam pack equipment	10
Steamer, vegetable.	10
Stencil machine	10
Sterilizer, movable	15
Stethophone	10
Stimulator, muscle	10
Stirrer	10
Stock pot	10
Stool, metal or wood	20
Stretcher	15
Suction pump	10
Table, anesthetic	15
Table, autopsy	20
Table, examining	15
Table, metal	20
Table, obstetrical	20
Table, operating	15
Table, refrigerated	10
Table, therapy	15
Table, wood	15
Tank, hot water	15
Tank, paraffin	15
Tank, soap	15
Television receiver	5
Tent, oxygen	8

ITEM	YEARS
Thermometer, electronic	10
Time recording equipment	10
Tissue processor	10
Titrator, automatic	10
Toaster, commercial type	10
Traction unit	10
Tractor	10
Transcribing equipment	10
Treadmill, electric	8
Truck, hot food	10
Tube tester	10
Tumbler	15
Typewriter, electric	5
Typewriter, manual	8
Ultrasonic cleaner	10
Urn, coffee	10
Urn, milk	10
Vacuum cleaner	8
Vending machine	10
Venetian blind	10
Ventilating fan	15
Vibrator	10
Video cassette recorder	5
Warmer, dish	10
Warmer, food	10
Washing machine, commercial type	10
Washing machine, domestic type	8
Waste receptacle, metal	10
Water cooler, bottle type or fountain type	10
Water purifier or softener	12
Wheelchair	5
X-ray developing tank	15
X-ray film dryer	8
X-ray film processor	8

ITEM	YEARS
X-ray image intensifier	5
X-ray unit, deep therapy	8
X-ray unit, mobile	8
X-ray unit, superficial therapy	8

(7-1-93)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.19 - RULES FOR ADULT FOSTER CARE HOMES IN IDAHO

DOCKET NO. 16-0319-9601

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2000 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 39-3305, Idaho Code.

DESCRIPTIVE SUMMARY: The pending rules are being adopted as proposed. The original text of the proposed rules was published in the August 7, 1996 Administrative Bulletin, Volume 96-8, page 160.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact John Hathaway at (208) 364-1863.

DATED this 21st day of June, 1999.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

IDAPA 16
TITLE 03
Chapter 19

RULES FOR ADULT FOSTER CARE HOMES IN IDAHO

This Rule Is Being Repealed In Its Entirety.

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho
Administrative Bulletin, Volume 96-8, August 7, 1996, page 160.**

**This rule has been adopted as Final by the Agency
and is now pending review by the
2000 Idaho State Legislature for final adoption.**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.19 - RULES GOVERNING CERTIFIED FAMILY HOMES
DOCKET NO. 16-0319-9901

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 1999.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 39-3505 and 39-3525(2), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

August 11, 1999, at 7:00 p.m.
Coeur d'Alene Inn, Hayden Room
414 West Appleway Ave., Coeur d'Alene, Idaho;

August 18, 1999, at 7:00 p.m.
Ameritel Inn, Pebble Creek Room
1440 Bench Rd., Pocatello, Idaho;

August 23, 1999, at 7:00 p.m.
Ameritel Inn, Tablerock Room
7965 W. Emerald, Boise, Idaho.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The 1996 Legislature passed H.B. 742 which amended the Idaho Board and Care Act and the Residential Care for the Elderly Act. Among other items it required that anyone provided care commercially to the elderly or individuals with a physical disability, mental illness, or developmental disability to meet at a minimum the requirements of the adult foster care or residential care rules depending upon the size of the facility. This includes adult foster care homes, 1501 homes, personal care services homes, specialized family homes, and residential care facilities.

In the past, each of these types of facilities operated with differing minimum requirements for safety, supervision, and care. The Department of Health and Welfare believes that a better approach is to develop one common set of standards for all residential facilities which must be licensed regardless of program type.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to Protect public health, safety, or welfare, and to comply with deadlines in amendments to governing law or federal programs.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

In accordance with the authority granted us in Sections 39-3505 and 39-3525(2), Idaho Code, these rules will require potential facilities to pay a building evaluation fee to determine if the building chosen to be the facility's physical plant, meets the requirements prior to being licensed.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact John Hathaway.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 25, 1999.

DATED this 21st day of June, 1999.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 334-5548 fax

THE FOLLOWING IS TEXT OF DOCKET NO. 16-0319-9901

IDAPA 16
TITLE 03
Chapter 19

16.03.19 - RULES GOVERNING CERTIFIED FAMILY HOMES

000. LEGAL AUTHORITY.

Pursuant to Section 39-3371 and Section 39-3561, Idaho Code, the Idaho Board of Health and Welfare is authorized to adopt and enforce rules and standards designed to protect the health and safety of residents in adult foster care homes and to provide adequate nutrition, supervision and meaningful life activities. Sections 39-3393 and 39-3580, Idaho Code, extend the adult foster care home provisions to any individual providing care commercially to persons who are developmentally disabled, mentally ill, physically disabled, or elderly. (7-1-99)T

001. TITLE AND SCOPE.

01. Title. These rules shall be cited in full as IDAPA 16.03.19.000 et seq., Idaho Department of Health and Welfare Rules IDAPA 16, Title 03, Chapter 19, "Rules Governing Certified Family Homes". (7-1-99)T

02. Scope. These rules include minimum standards and administrative requirements for any individual who is paid to care for an adult in the individual's home, if the adult cared for is developmentally disabled, mentally ill, physically disabled, or elderly, and needs assistance with activities of daily living.

002. (RESERVED)

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by the provision of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (7-1-99)T

004. WAIVERS.

Waivers may be granted by the Department when the following conditions are met: (7-1-99)T

01. Written Request. A written request for a waiver must be submitted to the Department. The request must include the following: (7-1-99)T

a. Reference to the section of the rules for which the waiver is requested; (7-1-99)T

b. Reasons that show good cause why the waiver should be granted, including any extenuating circumstances and any compensating factors or conditions that may have bearing on the waiver, such as additional floor space or additional staffing; (7-1-99)T

c. Written documentation that assures residents' health and safety will not be jeopardized if the waiver is granted. (7-1-99)T

02. One Year Limit On Waivers. A waiver may be granted for a period of no more than one (1) year. (7-1-99)T

03. Renewing A Waiver. The appropriateness of renewing a waiver shall be reviewed by the Department during the annual survey. If the home operator wishes to review the waiver, a request (unless specified otherwise) must be submitted to the certifying agency in writing. (7-1-99)T

04. Decision To Grant A Waiver. The decision to grant a waiver in one (1) home shall not be considered as precedent or be given any force or effect regarding any other home. (7-1-99)T

005. EXEMPTIONS.
The provisions of these rules do not apply to any of the following: (7-1-99)T

01. Health Facility. The provisions of these rules do not apply to any health facility defined by Title 39, Chapter 13, Idaho Code. (7-1-99)T

02. Alternate Living Arrangements. The provisions of these rules do not apply to any home that is limited to providing only housing, meals, transportation, housekeeping, or recreational and social activities, or that has residents independently accessing supportive services from an entity approved to provide such services in Idaho and holding no legal ownership interest in the home. (7-1-99)T

03. Relatives. The provisions of these rules do not apply to any arrangement for the receiving and care of persons by a relative, except when the caretaker is paid for the care through a state or federal program, in which case the caretaker relative and the care setting must meet the requirements of the program that funds the care.

006. SERVICES AVAILABLE.
The certified family home shall provide a home setting and supportive services according to the resident's Negotiated Service Agreement. (7-1-99)T

007. (RESERVED).

008. INCORPORATION BY REFERENCE.
The following documents are incorporated by reference. (7-1-99)T

01. The Uniform Building Code, 1988 Edition. Available from the International Conference of Building Officials, 5360 South Workman Mill Road, Whittier, CA, 90601. (7-1-99)T

02. IDAPA 16.03.22, "Rules For Licensed Residential And Assisted Living Facilities In Idaho," Sections 927 and 930. (7-1-99)T

009. (RESERVED).

010. DEFINITIONS.

01. Abuse. The nonaccidental infliction of physical pain, injury, or mental injury. (7-1-99)T

02. Activities. All organized and directed social, habilitative, and rehabilitative services a home provides or arranges. (7-1-99)T

- 03. Activities Of Daily Living.** The performance of basic self-care activities in meeting an individual's needs to sustain him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communicating, continence, managing money, mobility, and associated tasks. (7-1-99)T
- 04. Adequate Care.** The care and supervision provided to a resident to meet his needs for room, board, and assistance as described in the Negotiated Service Agreement. (7-1-99)T
- 05. Adult.** A person who has attained the age of eighteen (18) years. (7-1-99)T
- 06. Adult Foster Care Home.** A family home in which one (1) or two (2) adults live who are not able to reside in their own home and who require care, help in daily living, protection, security, and encouragement toward independence. Adult foster care homes are subject to these rules. (7-1-99)T
- 07. Advanced Directive.** A written instruction, such as a living will or durable power of attorney for health care, recognized under State Law, whether statutory or as recognized by the courts of the State, and relates to the provision of medical care when the individual is unable to communicate. (7-1-99)T
- 08. Advocate.** An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of persons with mental illness, developmental disabilities, physical disabilities, and/or who are elderly. (7-1-99)T
- 09. Ambulatory Person.** A person who, unaided by any other person, is physically and mentally capable of walking a normal path to safety, including the ascent and descent of stairs. (7-1-99)T
- 10. Assessment.** The conclusion reached using uniform criteria developed by the Department and relevant councils for determining a person's need for care and services. (7-1-99)T
- 11. Assistance With Medications.** Refer to the current Administrative Rules of the Idaho State Board of Nursing, IDAPA 23.01.01, "Rules of the Board of Nursing," Section 400, Subsections 400.02, 400.04, and 400.05. (7-1-99)T
- 12. Basement.** Any floor level below the first story in a home except that a floor level in a home having only one (1) floor level shall be classified as a basement. (7-1-99)T
- 13. Board.** The Idaho State Board of Health and Welfare. (7-1-99)T
- 14. Care And Supervision.** The provision by a provider of one (1) or more of the following services based on each resident's Negotiated Service Agreement: (7-1-99)T
- a. Assisting the resident with activities of daily living; (7-1-99)T
 - b. Arranging for supportive services; (7-1-99)T
 - c. Being aware of the resident's general whereabouts; (7-1-99)T
 - d. Monitoring the activities of the resident while on the premises of the home and knowledge of the resident's whereabouts to ensure the resident's health, safety, and well-being; (7-1-99)T
 - e. Assisting residents with self-administration of medication; (7-1-99)T
- 15. Certificate.** A permit issued by the Department to operate a certified family home. (7-1-99)T
- 16. Certified Family Home.** A family home in which an adult chooses to live who is not able to reside in his own home and who requires care, help in daily living, protection, security, and encouragement toward independence. This term includes adult foster care homes as defined in Section 39-3302(5) and Section 39-3502(5), Idaho Code, as well as any home in which care is provided commercially to one (1) or two (2) persons. In this chapter a Certified Family Home shall be referred to as "home". (7-1-99)T

- 17. Certified Family Home Care Provider.** An adult member of the certified family home responsible for providing care to the resident or residents. The care provider and the legal property owner may not necessarily be the same person. (7-1-99)T
- 18. Certified Family Home Care Agreement.** A written, signed, and dated agreement between a certified family home and a resident specifying the amount of payment to be paid by the resident and the method of payment. (7-1-99)T
- 19. Certified Family Home Family.** All individuals related by blood or marriage, other than residents, residing in the certified family home. (7-1-99)T
- 20. Certifying Agency.** The unit of the Department that conducts inspections and surveys and that issues certificates based on the home's compliance with this chapter. The unit of the Department may differ depending on the type of resident and the geographic area of the State. (7-1-99)T
- 21. Chemical Restraint.** The use of any medication that results or is intended to result in the modification of behavior. (7-1-99)T
- 22. Client Of The Department.** Any person who receives financial aid and/or services from an organized program of the Department. (7-1-99)T
- 23. Criminal Offense.** Any crime as defined in Section 18-111, Idaho Code, in 18 U.S.C. Section 4A1.2(o), and 18 U.S.C. Sections 1001 through 1027. (7-1-99)T
- 24. Deficiency.** A determination of non-compliance with a specific rule or part of a rule. (7-1-99)T
- 25. Department.** The Idaho Department of Health and Welfare. (7-1-99)T
- 26. Developmental Disability.** A developmental disability as defined in Section 66-402, Idaho Code, means chronic disability that occurs before the age of twenty-two (22), and: (7-1-99)T
- a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism, or other conditions found to be closely related to or similar to one of these impairments that requires similar treatment or services or is attributable to dyslexia resulting from such impairments; and (7-1-99)T
- b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and (7-1-99)T
- c. Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of life-long or extended duration and individually planned and coordinated. (7-1-99)T
- 27. Director.** The Director of the Idaho Department of Health and Welfare or his designee. (7-1-99)T
- 28. Exploitation.** An action which may include, but is not limited to, the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage. (7-1-99)T
- 29. Hands On.** Physical assistance to the resident beyond verbal prompting. (7-1-99)T
- 30. Immediate Jeopardy.** The certifying agency has determined that residents are subject to an imminent or substantial danger. (7-1-99)T
- 31. Independent Mobility.** A resident's ability to move about freely of their own choice with or without the assistance of a mobility device such as a wheelchair, cane, crutches, or walker. (7-1-99)T

32. Individual Support Plan. The written individualized plan approved by the Department, which must be based on a person-centered planning and assessment process outlining the consumers' needs, desires, goals, and objectives, and include the specific types, amounts, frequency, and duration of waiver services to be provided by the agency. (7-1-99)T

33. Level Of Care. A categorical assessment of the resident's functional ability and the degree of care required in the areas of activities of daily living, supervision, response to emergency situation, mobility, medications and behavior management. (7-1-99)T

34. Monitoring Visit. A representative of the Department visiting a home for the purpose of verifying a home's correction of deficiencies or to observe the orderly transfer of residents and/or a home closure. (7-1-99)T

35. Neglect. The failure to provide those goods or services which are reasonably necessary to sustain the life and health of a person pursuant to Section 39-5302(8), Idaho Code. (7-1-99)T

36. Negotiated Service Agreement. The agreement between the resident and/or their representative and the home, based on the assessment, physician's orders, if any, admission records, if any, and desires of the resident, and which outlines services to be provided and the obligations of the home and the resident. (7-1-99)T

37. Owner. Any recognized legal entity, governmental unit, or person having legal ownership of the certified family home. (7-1-99)T

38. Personal Care Services. Services provided pursuant to Section 39-5601 et seq., Idaho Code. (7-1-99)T

39. PRN. A medication or treatment prescribed by a medical professional to an individual allowing the medication to be given as needed. (7-1-99)T

40. Provider. The member of the family of the home who has primary responsibility for the care of the residents in the home and for compliance with the standards set forth in these rules. The certified family home certificate will be issued in the provider's name. The provider must be at least eighteen (18) years of age and must live in the home. (7-1-99)T

41. Relative(s). Persons related by birth, adoption, or marriage to the first degree and grandparent and grandchild. (7-1-99)T

42. Repeat Deficiency. A violation or deficiency found on a resurvey or revisit that was also found during the previous survey or visit. (7-1-99)T

43. Repeated Noncompliance. A finding of substandard quality of care on three (3) consecutive surveys and/or visits. (7-1-99)T

44. Resident, Certified Family Home. An individual who requires room and board, supervision, and one (1) or more of the following services: protection, assistance with decision-making and activities of daily living, and direction toward self-care skills. A resident of a certified family home is referred to in these rules as "resident". A resident includes all occupants of a certified family home other than the owner, provider, or their immediate families or employees. (7-1-99)T

45. Residential Habilitation. Services consisting of an integrated array of individually-tailored services and supports furnished to an eligible consumer which are designed to assist them to reside successfully in their own homes, with their families, or alternate family home. Residential Habilitation Homes are subject to the provisions of these rules. (7-1-99)T

46. Room And Board. Lodging and meals. (7-1-99)T

47. Self-Administration Of Medication. A resident taking a single dose of medication as a result of an order by a physician or a dentist. The certified family home provider is responsible for providing necessary

assistance to the resident in taking his medication, including reminding the resident to take medication, removing medication containers from storage, assisting with removal of the cap, assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act and observing the resident taking the medication. (7-1-99)T

48. Self-Preservation. A resident's ongoing ability to execute actions necessary to safeguard against personal harm, injury, or accident. (7-1-99)T

49. Service Coordinator. A regionally designated representative of the Department's Adult Services, Mental Health, or Developmental Disabilities Program who is qualified by training and experience including, but not limited to, licensed social worker or registered nurse to develop or coordinate Negotiated Services Agreements for clients of the Department. (7-1-99)T

50. Service Plan. The Negotiated Service Agreement, Personal Care Plan, Plan of Care, or Individual Service Plan. (7-1-99)T

51. Substandard Quality Of Care. A finding by the certifying agency of one (1) or more deficiencies, the existence of which limit(s) the home's ability to deliver adequate care or services. (7-1-99)T

52. Substantial Compliance. A home is in substantial compliance with these rules when there are no deficiencies which would endanger the health, safety, or welfare of the residents. (7-1-99)T

53. Uniform Assessment Instrument. A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities pursuant to IDAPA 16.03.23, "Rules Governing Uniform Assessments for State-Funded Clients". (7-1-99)T

54. Waiver Services. Home and Community Based (HCBS) Services which are subject to the requirements of these rules. (7-1-99)T

55. 1501 Home. A home authorized by Chapter 284 of the Idaho Session Laws of 1994 (S.B. 1501) codified at Section 39-3561(9) Idaho Code, to provide care and supervision for up to four (4) adults. Certification for a 1501 home is not transferable to another person or location other than as originally certified. Homes certified under this provision shall not be subject to the residential care facility administrator or residential care facility licensing requirements of Title 54, Chapter 42, of the Idaho Code, or Title 39, Chapters 33 and 35 of the Idaho Code. With the exception of the limitation on numbers of residents, 1501 homes are subject to these rules. (7-1-99)T

011. -- 099. (RESERVED).

100. CERTIFICATION.

01. Requirements. (7-1-99)T

a. After July 1, 1999, no person or entity, public or private shall establish or operate a home without first obtaining a certificate issued by the Department; (7-1-99)T

b. Any person or entity proposing to operate a home shall apply for certification to the Department, specifying the types of residents to be served and the level(s) of care to be provided; (7-1-99)T

c. A certificate to provide certified family care shall be issued in the name of the provider applying for certification, and only to the address of the home stated in the application. There shall be no change in the provider or location of the certified family home without a new certification study of the home; (7-1-99)T

d. As a condition of certification, the following goods or services shall be provided to the resident without additional charge: (7-1-99)T

- i. Appropriate, adequate supervision as outlined in the resident's Negotiated Service Agreement; (7-1-99)T
 - ii. Room and board; (7-1-99)T
 - iii. Furnishings and equipment as outlined in Subsection 700.06; (7-1-99)T
 - iv. Essential toiletries listed in Subsection 700.06; (7-1-99)T
 - v. Negotiated Service Agreement development and implementation; (7-1-99)T
 - vi. Activity supplies in reasonable amounts, that reflect the interests of the resident; and (7-1-99)T
 - vii. Arrangement of transportation in reasonable amounts to community, recreational, and religious activities within twenty-five (25) miles of the home. (7-1-99)T
- e. The home and physical premises as well as all records required under these rules, shall be accessible at all times to the certifying agency for the purposes of inspection, with or without prior notification. (7-1-99)T

02. Application For An Initial Certificate. The applicant/provider shall apply for certification on forms provided by the Department, giving such information as the Department shall require, including: (7-1-99)T

- a. A written statement that the applicant has thoroughly read and reviewed this chapter and is prepared to comply with all of its provisions; (7-1-99)T
- b. Satisfactory evidence that the applicant is of reputable and responsible character, including, but not limited to a criminal history clearance as provided in Idaho Department of Health and Welfare Rules, IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". If the applicant is unable to obtain an acceptable criminal history clearance, the Department shall deny the application; (7-1-99)T
- c. Completed application form signed by the applicant/provider; (7-1-99)T
- d. The applicant must provide a written statement that discloses any revocation or other disciplinary action taken or in the process of being taken against the applicant as a care provider in Idaho or any other jurisdiction, or that verifies that the applicant has never been involved in any such action; (7-1-99)T
- e. Any other information that may be requested by the certifying agency for the proper administration and enforcement of the provisions of this chapter; (7-1-99)T
- f. A statement from a licensed electrician or the local/state electrical inspector that all wiring in the home complies with applicable local codes; and (7-1-99)T
- g. If the home is on other than a municipal water supply or sewage disposal system, a statement from the local environmental health agency that the water supply and sewage disposal system meets the legal standards. (7-1-99)T

03. Additional Certification Requirements. (7-1-99)T

- a. Homes shall not be certified for more than two (2) residents; (7-1-99)T
- b. A home cannot be certified if it also provides room and board to any person who is not a resident as defined by these rules or a family member; (7-1-99)T
- c. Homes cannot be certified as a certified family home and for child foster care at the same time; and (7-1-99)T

d. The number, age, and sex of children or other adults in the home shall be taken into account in evaluating the appropriateness of a placement for meeting the needs of an adult. (7-1-99)T

e. Failure of the applicant to cooperate with the Department in the application process shall result in the denial of the application. Failure to cooperate means that the information described in Section 100 of the rules has not been provided, or not provided in the form requested by the certifying agency, or both. (7-1-99)T

04. Effect Of Previous Revocation Or Denial Of A Certificate Or A License. The certifying agency is not required to consider the application of any applicant who has had a health care certificate or license denied or revoked until five (5) years have lapsed from the date of denial or revocation. (7-1-99)T

05. State Certification To Supersede Local Regulation. These rules shall supersede any program of any political subdivision of the state which certifies or sets standards for certified family homes. (7-1-99)T

06. Certification Study. Following receipt of an acceptable application and other required signed documents, the Department shall initiate a certification study. The study shall include a review of all material submitted. The certification study, along with the application and other required material, shall serve as the basis upon which a certificate is issued or denied. The certifying agency shall schedule an on-site interview with the proposed provider and the provider's family to review the certification study, and to verify that the home is in compliance with these rules. A medical or psychological examination of the provider or family members may be required by the Department. (7-1-99)T

07. Provider Training. As a condition of initial certification, all providers shall receive training in the following areas: (7-1-99)T

a. Resident rights; (7-1-99)T

b. The psychosocial and physical needs of the residents; (7-1-99)T

c. The specific services and supervision that each resident requires; (7-1-99)T

d. Certification in first aid and CPR (Cardio-Pulmonary Resuscitation) shall be kept current; (7-1-99)T

e. Emergency procedures; (7-1-99)T

f. Fire safety, fire extinguisher, and smoke alarms; and (7-1-99)T

g. Complaint investigations and survey procedures; (7-1-99)T

08. Ongoing Training. All family home providers shall receive a minimum of eight (8) hours per year of ongoing Department-approved training in the provision of supervision, services, and care, to include the orientation training program required in Section 100 of this rule. (7-1-99)T

101. -- 149. (RESERVED).

150. ISSUANCE OF CERTIFICATES.

01. Provisional Certificate. Homes found to be in substantial compliance with these rules but which fail to comply in every detail may be issued a provisional certificate when failure to comply will not adversely affect the health and safety of the residents. A certificate issued on the basis of substantial compliance is contingent upon the correction of deficiencies in accordance with an agreed upon plan. Provisional certificates may be issued for up to six (6) months. (7-1-99)T

02. Full Certificate. A full certificate shall be valid for a period of time not to exceed twelve (12) months from the date of approval. The certificate shall expire at the end of its stated period unless it is continued in effect by agreement with the Department or by operation of law. (7-1-99)T

a. Each certificate issued shall be only for the premises and persons named in the application and shall not be transferable or assignable; (7-1-99)T

b. The certificate shall be available at the home upon request; and (7-1-99)T

c. The provisional certificate may be replaced with a full certificate when the certifying agency has completed a revisit to the home prior to the expiration of the provisional certificate and has determined that the home qualifies for a full certificate. (7-1-99)T

03. Expiration And Renewal Of Certificates. (7-1-99)T

a. The application for renewal of a certificate shall be submitted on a form prescribed by the certifying agency. The completed application shall be returned to the certifying agency at least thirty (30) days prior to the expiration of the existing certificate. (7-1-99)T

b. The existing certificate, unless suspended or revoked, shall remain in force and effect until the Department has acted upon the application renewal when such application for renewal is timely filed. (7-1-99)T

04. Change Of Ownership Certification Requirements. (7-1-99)T

a. Because certificates are not transferable from one (1) individual to another or from one (1) lessee to another or from one (1) location to another, when a change of ownership, lease, or location is undertaken, the home must be recertified and must follow the same procedure as a home that has never been certified; (7-1-99)T

b. 1501 home status may not be recertified on a transfer between individuals or from one (1) location to another. On recertification of any such home that is transferred, the general provisions of these rules will apply, and the home will be limited to two (2) residents; (7-1-99)T

c. The application for a change of ownership must be submitted to the certifying agency at least sixty (60) days prior to the proposed date of change; and (7-1-99)T

d. An application for change of ownership of a home that is leased from a person who is in litigation for failure to meet licensure standards, or who has had his license revoked, shall include evidence that there is a bonafide arms length agreement and relationship between the two (2) parties. See Subsection 111.02.h. (7-1-99)T

05. Denial Of Certificate. The Department may deny the issuance of a certificate when such conditions exist as to endanger the health, safety, or welfare of any resident or when the home is not in substantial compliance with these rules. Additional causes for denial of a certificate include the following: (7-1-99)T

a. The applicant or provider has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; or (7-1-99)T

b. The applicant or provider has been guilty of fraud, gross negligence, abuse, assault, battery or exploitation in relationship to the operation of a health facility or certified family home; or (7-1-99)T

c. The applicant or provider has been convicted of a criminal offense described in Section 39-3321(1), Idaho Code, within the past five (5) years; or (7-1-99)T

d. The applicant or provider has been denied or has had revoked any health facility license, residential and assisted living facility license, or certified family home certificate; or (7-1-99)T

e. The applicant or provider has been convicted of operating any health facility, residential and assisted living facility, or certified family home without a license/certificate; or (7-1-99)T

f. The applicant or provider has been enjoined from operating a health facility, residential and assisted living facility, or certified family home; or (7-1-99)T

g. The applicant or provider is directly under the control or influence of any person who is described by Subsections 150.05.a. through 150.05.f. (7-1-99)T

06. Revocation Of Certificate. The Department may revoke any certificate when conditions exist which endanger the health, safety, or welfare of any resident, or when the home is not in substantial compliance with these rules. (7-1-99)T

07. Emergency Powers Of The Director. In the event of an emergency endangering the life or safety of a resident, the Director may summarily suspend or revoke any certified family home certificate. As soon thereafter as practicable, the Director shall provide an opportunity for a hearing in accordance with the provisions of IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings and Declaratory Rulings". (7-1-99)T

08. Uncertified Family Homes. No uncertified family home shall operate in this state: (7-1-99)T

a. An "uncertified family home" shall not operate in the state if it is "operated to provide family home services," is not certified, is not exempt from certification, provides care commercially, and any one (1) of the following conditions exists: (7-1-99)T

i. The home is, or is held out as or represented as, providing care, supervision, and services; or (7-1-99)T

ii. The home accepts or retains residents who demonstrate the need for care, supervision, and services, as defined by these rules. (7-1-99)T

b. Upon discovery of an uncertified family home, the Department shall refer residents to the appropriate placement or adult protective services agency if there is an immediate threat to any resident's health and safety or if the home does not cooperate with the certifying agency to apply for certification, meet certification standards, and obtain a valid certificate. (7-1-99)T

c. A person found to be operating a certified family home without first obtaining a certificate may be referred for criminal prosecution pursuant to Section 39-3381, Idaho Code. (7-1-99)T

09. Placement Of Persons Into An Uncertified Family Home. No person or public agency employee shall place, refer, or recommend placement of a person into a family home which is operating without a certificate. (7-1-99)T

10. Procedure For Hearings For Denial Or Revocation Of A Certificate. (7-1-99)T

a. Immediately upon the denial of any application for a certificate, or the revocation of a certificate, the Department shall notify the applicant or operator in writing by certified mail or by personal service of its decision and the reason for its decision; (7-1-99)T

b. The notification shall also offer the applicant or the operator the opportunity to request an informal prehearing conference during which alternatives to revocation or denial may be discussed; and (7-1-99)T

c. If the case cannot be resolved in the prehearing conference, or if the applicant or operator does not request a prehearing conference, the case shall be subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings and Declaratory Rulings". (7-1-99)T

151. INSPECTIONS.

01. Inspection Of Homes. (7-1-99)T

a. The certifying agency shall cause to be made such inspections and investigations, based on previous survey experience, as it may deem necessary to determine compliance with this chapter and applicable rules and standards. (7-1-99)T

b. All inspections and investigations for such purposes, except for the initial certification study, shall be made unannounced and without prior notice. (7-1-99)T

c. The Department may utilize the services of any legally qualified person or organization, either public or private, to examine and inspect any home requesting certification. (7-1-99)T

d. A surveyor or inspector shall have full access and authority to examine quality of care and services delivery, resident records, records including any records or documents pertaining to any financial transactions between residents and the home, resident accounts, physical premises, including the condition of the home, grounds and equipment, food service, water supply, sanitation, maintenance, housekeeping practices, and any other areas necessary to determine compliance with these rules and standards. (7-1-99)T

e. A surveyor shall have the authority to interview the family home provider and family members, residents and residents' families. Interviews with residents shall be confidential and conducted privately unless otherwise specified by the resident. (7-1-99)T

f. The surveyor shall have full authority to inspect the entire home, accompanied by the provider, including personal living quarters of family members living in the home, to check for inappropriate storage of combustibles, faulty wiring, or other conditions that may have a direct impact on the operation of the certified family home. (7-1-99)T

g. Following any investigation or inspection, the certifying agency shall provide a written report to the provider of the home within thirty (30) days of the investigation or inspection. The report shall include the findings of the investigation or inspection. (7-1-99)T

h. If deficiencies are identified during the investigation or inspection, the home shall be sent a statement of deficiencies which requires a plan of correction. (7-1-99)T

i. An acceptable plan of correction must include how the deficiency was corrected or how it shall be corrected, what steps have been taken to assure that the deficiency does not reoccur, and acceptable time frames for correction of the deficiency. (7-1-99)T

j. Depending on the severity of the deficiency, the home shall be given fourteen (14) calendar days to develop a written plan of correction and to return the plan of correction to the certifying agency. (7-1-99)T

k. Follow-up surveys may be conducted to ascertain if corrections to deficiencies are being made according to time frames established in the plan of correction. (7-1-99)T

02. Complaint Procedures. Any person who believes that any rule has been violated by a home may file a complaint with the certifying agency. (7-1-99)T

a. The certifying agency shall investigate, or cause to be investigated, any complaint alleging a violation of these rules. Any complaint involving the abuse, neglect, or exploitation of an adult shall be referred to adult protective services in accordance with the Adult Abuse, Neglect, and Exploitation Act. (7-1-99)T

b. No complainant's name or other information that can identify a complainant shall be publicly disclosed unless: (7-1-99)T

i. The complainant consents in writing to the disclosure; (7-1-99)T

ii. The investigation results in a judicial proceeding and disclosure is ordered by the court; or (7-1-99)T

iii. The disclosure is essential to the investigation. The complainant shall be given the opportunity to withdraw the complaint before disclosure. (7-1-99)T

c. The nature of the complaint shall determine the method used to investigate the complaint. On-site investigations at the home shall be unannounced. (7-1-99)T

d. The certified family home shall be offered an exit conference where the findings of the investigation shall be discussed. (7-1-99)T

e. If violation of these rules are identified, depending on the severity, the home shall be sent a statement of deficiencies and shall be required to prepare a plan of correction and return it to the certifying agency within a time frame designated by the certifying agency. (7-1-99)T

f. The certifying agency shall inform the complainant or, if requested by the complainant, the complainant's representative, of the results of the investigation, any action taken by the home to resolve the problem, and any further action taken by the Department. (7-1-99)T

03. Public Disclosure. Information received by the Department through filed reports, inspection, or as otherwise authorized under the law, shall not be disclosed publicly in such a manner as to identify individual residents except in a proceeding involving a question of certification. (7-1-99)T

a. A current list of deficiencies including plans of correction shall be available to the public upon request in the individual homes or by written request to the certifying agency. (7-1-99)T

04. Transfer Of Residents. The Department may transfer residents from a certified family home to an alternative placement on the following grounds: (7-1-99)T

a. As a result of a violation of this chapter or applicable rules, or standards, the home is unable or unwilling to provide an adequate level of meals, lodging, care, or supervision to persons residing in the home at the time of the violation; (7-1-99)T

b. A violation of a resident's rights provided in Section 39-3316, Idaho Code; (7-1-99)T

c. The home is operating without a certificate; or (7-1-99)T

d. A violation of this chapter or applicable rules or standards results in conditions that present an imminent danger. (7-1-99)T

152. -- 199. (RESERVED).

200. RESIDENTS' RIGHTS.

01. Residents' Rights Policy. Each certified family home shall develop and implement a written residents' rights policy which shall protect and promote the rights of each resident including, but not limited to, the following: (7-1-99)T

a. Each home must maintain and keep current a record of the following information on each resident: (7-1-99)T

i. A copy of the resident's current Negotiated Service Agreement or physician's order; (7-1-99)T

ii. Written acknowledgment that the resident has received copies of the rights; (7-1-99)T

iii. A record of all personal property and funds which the resident has entrusted to the home including copies of receipts for the property; (7-1-99)T

iv. Information about any specific health problems of the resident which may be useful in a medical emergency; (7-1-99)T

v. The name, address, and telephone number of an individual identified by the resident who should be

- contacted in the event of an emergency or death of the resident; (7-1-99)T
- vi. Any other health-related, emergency, or pertinent information which the resident requests the home to keep on record; and (7-1-99)T
 - vii. The current admission agreement between the resident and the home. (7-1-99)T
- b. Each resident must be assured the right to privacy with regard to accommodations, medical and other treatment, written and telephone communications, visits and meetings of family and resident groups; (7-1-99)T
- c. Each resident shall have the right to humane care and a humane environment, including the following: (7-1-99)T
- i. The right to a diet which is consistent with any religious or health-related restrictions; (7-1-99)T
 - ii. The right to refuse a restricted diet; and (7-1-99)T
 - iii. The right to a safe and sanitary living environment. (7-1-99)T
 - d. Each resident shall have the right to be treated with dignity and respect, including: (7-1-99)T
 - i. The right to be treated in a courteous manner by the provider; (7-1-99)T
 - ii. The right to receive a response from the home to any request of the resident within a reasonable time; (7-1-99)T
 - iii. Freedom from discrimination; and (7-1-99)T
 - iv. Freedom from intimidation, manipulation, coercion, and exploitation. (7-1-99)T
 - e. Each resident shall have the right to: (7-1-99)T
 - i. Wear his own clothing; (7-1-99)T
 - ii. Determine his own dress and hair style; (7-1-99)T
 - iii. Retain and use his own personal property in his own living area so as to maintain individuality and personal dignity; and (7-1-99)T
 - iv. Be provided a separate storage area in his own living area and at least one (1) locked cabinet or drawer, if the resident requests and is capable of managing lock and key, for keeping personal property. (7-1-99)T
 - f. Residents whose board and care is paid for by public assistance shall retain, for their personal use, the difference between their total income and the applicable board and care allowance established by Department rules: (7-1-99)T
 - i. Residents shall have the right to manage their personal funds; (7-1-99)T
 - ii. A home shall not require a resident to deposit his personal funds with the home; and (7-1-99)T
 - iii. Once the home accepts the written authorization of the resident, the home must hold, safeguard, and account for such personal funds under a system established and maintained by the home in accordance with Subsections 205.01 through 205.02; (7-1-99)T
 - g. Upon a home's acceptance of written authorization of a resident, the home must manage and account for the personal funds of the resident deposited with them in accordance with Subsections 205.01 and 205.02; (7-1-99)T

- h. Each home must permit: (7-1-99)T
- i. Immediate access to any resident by any representative of the Department, by the state Ombudsman for the elderly or his designees, or by the resident's individual physician; (7-1-99)T
- ii. Immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives; (7-1-99)T
- iii. Immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident; and (7-1-99)T
- iv. Reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. (7-1-99)T
- i. Each resident shall have the right to refuse to perform services for the home; (7-1-99)T
- j. Each resident shall have access to his personal records and shall have the right to confidentiality of personal and clinical records; (7-1-99)T
- k. Each resident shall have the right to be free from physical, mental, or sexual abuse, neglect, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience: (7-1-99)T
- i. Any physician, nurse, employee of a public or private health facility, or a state certified family home serving vulnerable adults, medical examiner, dentist, ombudsman for the elderly, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, or exploited shall immediately report such information to the Idaho Commission on Aging or its Area Agencies on Aging (Section 39-5303, Idaho Code). (7-1-99)T
- ii. It is the home's responsibility to report within four (4) hours to the appropriate law enforcement agency when there is reasonable cause to believe that abuse, neglect, misappropriation of resident's property, or sexual assault has resulted in death or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult resident (refer to Idaho Code, Sections 39-5303 and 39-5310). (7-1-99)T
- l. Each resident shall have the right to practice the religion of his choice or to abstain from religious practice. Residents shall also be free from the imposition of the religious practices of others; (7-1-99)T
- m. Each resident shall have the right to control his health-related services, including: (7-1-99)T
- i. The right to retain the services of his own personal physician and dentist; (7-1-99)T
- ii. The right to select the pharmacy or pharmacist of his choice; (7-1-99)T
- iii. The right to confidentiality and privacy concerning his medical or dental condition and treatment; (7-1-99)T
- iv. The right to participate in the formulation of his Negotiated Service Agreement. (7-1-99)T
- n. Each resident shall have the right to voice/file a grievance with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievance and the right to prompt efforts by the home to resolve grievances the resident may have, including those with respect to the behavior of other residents; (7-1-99)T
- o. Each resident shall have the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the home; (7-1-99)T

p. Each resident shall have the right to examine, upon reasonable request, the results of the most recent survey of the home conducted by the Department with respect to the home and any plan of correction in effect with respect to the home; (7-1-99)T

q. Is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay and in nonemergency conditions is given at least fifteen (15) calendar days advance written notice prior to the date of discharge or transfer or up to thirty (30) days as agreed to in the admission agreement; (7-1-99)T

r. The resident has a right to review a list of other certified family homes that may be available to meet his needs in case of transfer; (7-1-99)T

s. Residents shall have a right not to be required to receive routine care of a personal nature from a member of the opposite sex; (7-1-99)T

t. Residents shall have the right to send and receive mail unopened; (7-1-99)T

u. If the resident is married, he is assured privacy for visits by his spouse. If both are residents in the home, they are permitted to share a room unless medically contraindicated (as documented by the attending physician); (7-1-99)T

v. Advanced Directives. Elderly residents shall have the right to be informed, in writing, regarding the formulation of an advanced directive to include applicable State law. (7-1-99)T

w. Each resident shall have any other right established by law. (7-1-99)T

02. Notice Of Rights. Each certified family home shall: (7-1-99)T

a. Inform each resident, verbally and in writing, at the time of admission to the home, of his legal rights during the stay at the home; (7-1-99)T

b. The written description of legal rights in Section 200, shall include a description of the protection of personal funds and a statement that a resident may file a complaint with the certifying agency respecting resident abuse and neglect and misappropriation of resident property in the home. (7-1-99)T

03. Access By Advocates And Representatives. A certified family home shall permit advocates and representatives of community and legal services programs, whose purposes include rendering assistance without charge to residents, to have access to the home at reasonable times in order to: (7-1-99)T

a. Visit, talk with and make personal, social service programs and legal services available to all residents; (7-1-99)T

b. Inform residents of their rights and entitlements, their corresponding obligations under state, federal, and local laws by distribution of educational materials or discussion in groups and with individuals; (7-1-99)T

c. Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance, and social security benefits, as well as in all other matters in which residents are aggrieved. This assistance may be provided individually, or in a group basis, and may include organizational activity, counseling, and litigation; (7-1-99)T

d. Engage in all other methods of assisting, advising and representing residents so as to extend to them the full enjoyment of their rights; (7-1-99)T

e. Communicate privately and without restrictions with any resident who consents to the communication; (7-1-99)T

- f. Observe all common areas of the home. (7-1-99)T

201. UNIFORM ASSESSMENT CRITERIA.

01. Home's Responsibility For Private-Pay Residents. The home shall develop, identify, assess, or direct a uniform needs assessment of private-pay residents age eighteen (18) or older who seek supported living services. The Department's uniform assessment instrument may be used as the home's identified uniform needs assessment. (7-1-99)T

02. Information To Be Included In A Uniform Needs Assessment. The uniform needs assessment instrument used by the home for private-pay residents shall include, but not be limited to: (7-1-99)T

- a. Identification/background information; (7-1-99)T
- b. Medical diagnosis; (7-1-99)T
- c. Medical and health problems; (7-1-99)T
- d. Prescription and over-the-counter medications; (7-1-99)T
- e. Behavior patterns; (7-1-99)T
- f. Cognitive function; (7-1-99)T
- g. Functional status; and (7-1-99)T
- h. Assessed level of care. (7-1-99)T

03. Qualifications Of Persons Making Uniform Needs Assessments For Private-Pay Residents. The uniform needs assessment shall be conducted by persons who are trained by the home in administering the home's identified uniform needs assessment instrument. (7-1-99)T

04. Time Frames For Completing The Uniform Needs Assessment Instrument For Private-Pay Residents. The assessment will be completed no later than fourteen (14) calendar days after admission. The assessment shall be reviewed when there is a change in need, or every twelve (12) months, whichever comes first. (7-1-99)T

05. Use Of Uniform Needs Assessment For Determining The Ability Of Home To Meet Private-Pay Resident Needs. The results of the assessment may be used to evaluate the ability of a provider and home to meet the identified residents' needs. The results of the assessment may also be used to determine the need for special training or licenses or certificates that may be required in caring for certain residents. (7-1-99)T

06. Uniform Assessments For State-Funded Clients. State-funded clients shall be assessed by the Department in accordance with IDAPA 16.03.23, "Rules Governing Uniform Assessments for State-Funded Clients". (7-1-99)T

202. NEGOTIATED SERVICE AGREEMENT.

01. Use Of Negotiated Service Agreement. Each resident shall be provided a negotiated service agreement to provide for coordination of services and for guidance of the personnel and management of the home where the person resides. A personal care services plan of care and/or an Individual Support Plan which includes the core elements of the Negotiated Service Agreement is considered equivalent to the Negotiated Service Agreement. Upon completion, the agreement shall clearly identify the resident and describe the services to be provided to the resident and how such services are to be delivered. (7-1-99)T

02. Core Elements Of The Negotiated Service Agreement, Plan Of Care, Or Individual Support

- Plan.** A resident's service plan shall be based on the following, but not limited to: (7-1-99)T
- a. Assessment; (7-1-99)T
 - b. Service needs for activities of daily living; (7-1-99)T
 - c. Need for limited nursing services; (7-1-99)T
 - d. Need for medication assistance; (7-1-99)T
 - e. Frequency of needed services; (7-1-99)T
 - f. Level of assistance; (7-1-99)T
 - g. Habilitation/Training needs, to specify the program being used; (7-1-99)T
 - h. Behavioral management needs, to include a specific plan which identifies situations that trigger inappropriate behavior; (7-1-99)T
 - i. Physician's signed and dated orders; (7-1-99)T
 - j. Admission records; (7-1-99)T
 - k. Community support systems; (7-1-99)T
 - l. Resident's desires; (7-1-99)T
 - m. Transfer/discharge; and (7-1-99)T
 - n. Other identified needs. (7-1-99)T

03. Signature And Approval Of Agreement. The provider and resident/resident's legal guardian/conservator, shall sign the service plan upon its completion, not to exceed fourteen (14) calendar days after the resident's admission. For personal care services and specialized family homes serving state clients, the services must be authorized by the Department prior to admission. (7-1-99)T

04. Signing Date That The Plan Was Approved. The provider and resident/resident's legal guardian/conservator shall date the service plan upon its completion, not to exceed fourteen (14) calendar days after the resident's admission. (7-1-99)T

05. Review Date. The service plan shall document the next scheduled date of review. (7-1-99)T

06. Development Of The Service Agreement. The home provider shall consult the resident and those other relevant persons identified by the resident in the development of their service agreement. As required by applicable program requirements, licensed and/or professional staff will be involved in the development of the plan. (7-1-99)T

07. Provision Of Copy Of Agreement. Signed copies of the agreement shall be given to the resident, to the resident's legal guardian/conservator, or for state-funded clients, to the Department for review, and authorization and approval, and a copy placed in the resident's records file, no later than fourteen (14) calendar days from admission. (7-1-99)T

08. Resident Choice. A resident shall be given the choice and control of how and what services the home will provide, or external vendors will provide to the extent the resident can make choices. (7-1-99)T

09. Record. A record shall be made of any changes or inability to provide services outlined in the negotiated service agreement. (7-1-99)T

10. External Services. The agreement shall include a statement regarding when there is no need for access to external services. (7-1-99)T

11. Periodic Review. The negotiated service agreement may be reviewed as necessary but must be reviewed at least every six (6) months. (7-1-99)T

203. ADMISSIONS.

01. Admission Agreements. Prior to admission to a certified family home, the home and the resident shall enter into an admission agreement. The agreement shall be in writing and shall be signed by both parties and shall, in itself or by reference to the resident's plan of care, include as a minimum the following: (7-1-99)T

a. Services that the home shall provide including, but not limited to, daily activities, recreational activities, maintenance of self-help skills, assistance with activities of daily living, arrangements for medical and dental services and provisions for trips to social functions, special diets, and arrangements for payments; (7-1-99)T

b. Whether or not the resident shall assume responsibility for his own medication including reporting missed medication or medication taken on a PRN basis; (7-1-99)T

c. Whether or not the home shall accept responsibility for the residents' personal funds; (7-1-99)T

d. How a partial month's refund shall be handled; (7-1-99)T

e. Responsibility for valuables belonging to the resident and provision for the return of residents' valuables should the resident leave the home; (7-1-99)T

f. The type of resident and the level of resident that shall be admitted to the home; (7-1-99)T

g. Fifteen (15) calendar days' written notice or up to thirty (30) calendar days as agreed to in the admission agreement prior to transfer or discharge on the part of either party; (7-1-99)T

h. Conditions under which emergency transfers shall be made; (7-1-99)T

i. Signed permission to transfer pertinent information from the resident's record to a hospital, nursing home, residential and assisted living facility, or other certified family home; (7-1-99)T

j. Resident responsibilities as appropriate; and (7-1-99)T

k. Other information as may be appropriate. (7-1-99)T

02. Conditions Of Termination Of The Admission Agreement. The admission agreement shall not be terminated except under the following conditions: (7-1-99)T

a. By written notification by either party giving the other party fifteen (15) calendar days' written notice; (7-1-99)T

b. The resident's mental or physical condition deteriorates to a level requiring evaluation and/or service that cannot be provided in a certified family home; (7-1-99)T

c. Nonpayment of the resident's bill; (7-1-99)T

d. In emergency conditions a resident may be transferred out of the home without fifteen (15) calendar days' written notice to protect the resident or other residents in the home from harm; and (7-1-99)T

e. Other written conditions as may be mutually established between the resident and the provider of the home at the time of admission. (7-1-99)T

204. RESIDENT RECORDS.

01. Admission Records. Records required for admission to a home shall be maintained and updated and shall be confidential. Their availability without the consent of the resident, subject to IDAPA16.05.01, "Rules Governing the Protection and Disclosure of Department Records," shall be limited to the home staff, professional consultants, the resident's physician and representatives of the certifying agency. All entries shall be kept current, recorded legibly in ink, dated, signed, and shall include, but not be limited to, the following: (7-1-99)T

- a. Name and Social Security number; and (7-1-99)T
- b. Permanent address if other than the home; and (7-1-99)T
- c. Marital status and sex; and (7-1-99)T
- d. Birth place and date of birth; and (7-1-99)T
- e. Name and addresses of responsible agent or agency including telephone numbers; and (7-1-99)T
- f. Personal physician and dentist; and (7-1-99)T
- g. Admission date and name of person who completed admission form; and (7-1-99)T
- h. Results of a history and physical examination performed by a licensed physician or nurse practitioner within six (6) months prior to admission; and (7-1-99)T
- i. For private-pay residents, the history and physical should include a description of the functional abilities of the resident including his specific strengths and limitations and the specific needs for personal assistance and supervision indicating that the resident is appropriate for placement in a home; and (7-1-99)T
- j. A list of medications, diet, and treatments prescribed for the resident which is signed and dated by the physician giving the order; and (7-1-99)T
- k. Religious affiliation if resident chooses to so state; and (7-1-99)T
- l. Interested relatives and friends other than those outlined in Subsection 204.01.e. to include names, addresses, and telephone numbers of family members, legal guardian/conservator, or significant others, or all; and (7-1-99)T
- m. For clients of the Department a psychosocial history, completed within six (6) months prior to admission, by a licensed social worker, psychologist, psychiatrist, or licensed physician; and (7-1-99)T
- n. Social information, obtained by the home through interview with the resident, family, case manager, targeted service coordinator, legal guardian/conservator, or all. The information shall include the resident's social history, hobbies, and interests; and (7-1-99)T
- o. Written admission agreement which is signed and dated by the provider and the resident/resident's legal guardian/conservator; and (7-1-99)T
- p. A signed copy of the resident's bill of rights as detailed in Section 200.02, or documentation that the resident or resident's legal guardian/conservator has read and understands his rights as a resident of the home; and (7-1-99)T
- q. A copy of the resident's admission Uniform Assessment Instrument for the certified family home; and (7-1-99)T
- r. A copy of the signed and dated admission negotiated service agreement, plan of care, or individual

support plan that contains all elements of a negotiated service agreement between the resident/resident's legal guardian/conservator and the home. (7-1-99)T

02. Ongoing Resident Records. At the time of admission, resident can inventory any item they choose. That inventory can be updated at any time during their stay. Records shall be kept current, to include but not be limited to: (7-1-99)T

- a. Admission information as required in Section 204.01 of this Chapter; and (7-1-99)T
- b. A current list of medications, diet, and treatments prescribed for the resident which is signed and dated by the physician giving the order. Current orders may be a copy of the signed doctor's order from the pharmacy; and (7-1-99)T
- c. Any incident/accident occurring while the resident is in the home; and (7-1-99)T
- d. Documentation of any medication refused by the resident, not given to the resident or not taken by the resident with the reason for the omission. All PRN medication shall be documented with the reason for taking the medication; and (7-1-99)T
- e. Notes from the contract nurse, home health, physical therapy, or other service providers, or all documenting the services provided at each visit; and (7-1-99)T
- f. Documentation of significant changes in the residents' physical, mental status, or both and the home's response; and (7-1-99)T
- g. If appropriate, the resident's financial trust fund accounting records; and (7-1-99)T
- h. The resident's Uniform Assessment Instruments, to include the admission assessment and all assessments for the past year, for certified family home care; and (7-1-99)T
- i. Signed and dated negotiated service agreement or individual support plan, to include the admission negotiated service agreement and all service agreements for the past year between the resident/resident's legal guardian/conservator and the home; and (7-1-99)T
- j. Contact name, address, phone number of individuals providing paid supports; and (7-1-99)T
- k. Signed copies of all care plans that are prepared by all outside service agencies. (7-1-99)T

03. Maintenance Of Resident Records. Resident records shall be maintained at the home for not less than one (1) year after the resident has left the home. (7-1-99)T

205. RESIDENT CHARGES AND FINANCIAL RECORDS.

01. Resident Funds Policies. If a resident's funds are turned over to the home or provider for any purpose other than payment for services allowed under these rules, or if the home provider, his relative, or personnel act as resident payee the home will be deemed to be handling residents' funds. Each home shall develop and implement a policy and procedure outlining how residents' funds shall be handled. This policy and procedure shall include, but not be limited to, the following: (7-1-99)T

- a. The home policy and procedure shall state whether the home shall or shall not handle residents' funds; (7-1-99)T
- b. This policy or procedure shall be clearly stated in the admission policy and in the admission agreement; and (7-1-99)T
- c. If the home is deemed to manage funds and the resident leaves the home under any circumstances,

the home can only retain room and board funds prorated to the last day of the fifteen (15) calendar day notice period, or thirty (30) calendar day notice period per agreement, or upon moving from the home, whichever is later. All remaining funds must follow the resident, and resident funds must be used for resident expenses until a new payee is appointed. (7-1-99)T

02. Handling Of Resident Funds. If the home agrees to handle residents' funds, the following shall apply: (7-1-99)T

a. A separate trust account must be established. There can be no commingling of trust funds with home funds. Borrowing between resident accounts is prohibited; (7-1-99)T

b. Each resident shall be notified that a trust fund is available for his use if he needs this service; (7-1-99)T

c. If it is determined that a resident needs the use of a trust fund service, the home shall be required to deposit the residents' funds into the trust fund; (7-1-99)T

d. Bill each resident for his certified family home care charges on a monthly basis from the trust account; (7-1-99)T

e. Document on a monthly or on a weekly basis any financial transactions in excess of five dollars (\$5) between the resident and the home or any of the home's personnel. A separate transaction record shall be maintained for each resident; (7-1-99)T

f. In any case in which the home cannot produce proper accounting records of residents' funds or property, the home shall be presumed to owe the funds not accounted for to the resident and restitution of the funds to the resident shall be a condition for continued operation of the home; (7-1-99)T

g. The home shall not require the resident to purchase goods or services from the home for other than those designated in the admission policies, or the admission agreement, or both. See Section 203; (7-1-99)T

h. The home shall afford the resident or the resident's legal guardian/conservator or person of the resident's choosing access to the resident's financial record; (7-1-99)T

i. The home shall afford the resident reasonable access to his funds; (7-1-99)T

j. Upon the death of a private-pay resident, with a trust fund, the home must convey the resident's personal funds and a final accounting of such funds to the individual administering the resident's estate within ninety (90) days; and (7-1-99)T

k. Upon the death of a client of the Department, with a trust fund, the home must convey the resident's personal funds and a final accounting of such funds to the Department within thirty (30) days. (7-1-99)T

206. ENVIRONMENTAL SANITATION STANDARDS.

The home is responsible for the prevention of disease and for the maintenance of sanitary conditions. (7-1-99)T

01. Water Supply. The water supply for the home shall be adequate, of a safe, sanitary quality and: (7-1-99)T

a. A Department approved private, public or municipal water supply shall be used; (7-1-99)T

b. If water is from a private supply, water samples shall be submitted to the Department through a private accredited laboratory or the District Public Health Laboratory for bacteriological examination at least annually or more frequently if deemed necessary by the Department. Copies of the laboratory reports shall be kept on file at the home; and (7-1-99)T

c. There shall be a sufficient amount of water under adequate pressure to meet the sanitary

requirements of the home at all times. (7-1-99)T

02. Sewage Disposal. All sewage and liquid wastes shall be discharged, collected, treated, and disposed of in a manner approved by the Department. If the facility is not utilizing an approved municipal sewage treatment system, a statement must be obtained from a local environmental health specialist indicating that the sewage disposal system meets the requirements of the Department. The reports shall be kept on file at the home and shall be kept current. (7-1-99)T

03. Garbage And Refuse Disposal. Garbage and refuse disposal shall be provided by the home. (7-1-99)T

a. Garbage containers outside the home used for storage of garbage and refuse shall be constructed of durable, nonabsorbent materials and shall not leak or absorb liquids. Containers shall be provided with tight-fitting lids. (7-1-99)T

b. Garbage containers shall be maintained in good repair. Sufficient containers shall be afforded to hold all garbage and refuse which accumulates between periods of removal from the premises. Storage areas shall be kept clean and sanitary. (7-1-99)T

04. Insect And Rodent Control. The home shall be maintained free from infestations of insects, rodents and other pests. Chemicals (pesticides) used in the control program shall be selected, stored, and used in the following manner: (7-1-99)T

a. The chemical shall be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer; (7-1-99)T

b. The home shall take the necessary precautions to protect residents from obtaining toxic chemicals or cleaning supplies that are being stored either in individual resident rooms or by the home; (7-1-99)T

05. Yards. The yards surrounding the home shall be maintained to at least the standards of the surrounding neighborhood. (7-1-99)T

06. Linen-Laundry Facilities And Services. Adequate facilities shall be provided for the proper and sanitary washing of linen and other washable goods laundered at the home. (7-1-99)T

07. Housekeeping And Maintenance. Sufficient housekeeping and maintenance shall be provided to maintain the interior and exterior of the home in a clean, safe, and orderly manner. (7-1-99)T

a. Prior to occupancy of any sleeping room by a new resident, the room shall be thoroughly cleaned including the bed, bedding, and furnishings; and (7-1-99)T

b. Deodorizers shall not be used to cover odors caused by poor housekeeping and unsanitary conditions. (7-1-99)T

207. -- 427. (RESERVED).

428. MEDICATION STANDARDS AND REQUIREMENTS.

01. Medication Policy. Each home shall develop and implement a written medication policy and procedure that outlines in detail the procedures to be followed regarding the handling of medications and to include the delegation requirements of the Administrative Rules of the Board of Nursing, IDAPA 23.01.01, "Rules of the Board of Nursing," Subsection 010.05, Section 400, Subsections 400.02, 400.04, and 400.05 where applicable. The medication policy shall include, but not be limited to, the following: (7-1-99)T

a. If the resident is responsible for his own medication, a written approval stating that the resident is capable of self-administration of medications, must be obtained from the resident's primary physician; (7-1-99)T

b. The home shall take the necessary precautions to protect residents from obtaining medications that are being stored either in individual resident rooms or by the home; and (7-1-99)T

c. The home shall be responsible for providing any necessary assistance to the resident in taking his medication. (7-1-99)T

02. Medication Distribution System. Medi-sets, blister pack, or other system as approved by the department must be filled by a pharmacist and appropriately labeled in accordance with pharmacy standards. A licensed nurse may fill Medi-sets, which must be appropriately labeled with medication name, dosage, amount, time to be taken, and any special instructions. (7-1-99)T

03. Assistance With Medication. PRN medications and temporary routine medications of fourteen (14) calendar days or less may be maintained in an appropriately labeled multidose container. Each medication must be given to the resident directly from the medi-set or blister pack or medication container. The resident must be observed taking the medication. (7-1-99)T

04. Unused Medication. Unused or discontinued medications shall not accumulate at the home for longer than thirty (30) calendar days, unless there is reason to believe that the medication will be reordered by the attending physician within a reasonable length of time. The unused medication shall be disposed of in a manner that it cannot be retrieved. A written record of all disposal of drugs shall be maintained in the home and shall include: (7-1-99)T

- a. A description of the drug, including the amount; (7-1-99)T
- b. The resident for whom the medication was prescribed; (7-1-99)T
- c. The reason for disposal; (7-1-99)T
- d. The method of disposal; and (7-1-99)T
- e. Signatures of responsible home personnel and a witness, resident's family, or home's nurse. (7-1-99)T

429. -- 599. (RESERVED).

600. FIRE AND LIFE SAFETY STANDARDS.

Certified family homes must meet all the requirements of local and state codes concerning fire and life safety that are applicable to certified family homes. (7-1-99)T

01. General Requirements. General requirements for the fire and life safety standards for a certified family home are: (7-1-99)T

a. The home shall be structurally sound and shall be equipped and maintained to assure the safety of residents, employees, and the public; (7-1-99)T

b. On the premises of all homes where natural or man-made hazards are present, suitable fences, guards, and railing must be provided to protect the residents, in accordance with the residents' level of supervision needs as documented in the Negotiated Service Agreement; and (7-1-99)T

c. The premises of the certified family home shall be kept free from the accumulation of weeds, trash, and rubbish. (7-1-99)T

02. Fire/Life Safety Requirements. (7-1-99)T

a. Smoke detectors shall be installed throughout the home. The locations and number of smoke detectors shall be determined during the initial certification study; (7-1-99)T

- b. Any locks installed on exit doors shall be single action, easily openable from the inside without the use of keys or any special knowledge; (7-1-99)T
- c. Portable comfort heating devices of any kind shall be prohibited; (7-1-99)T
- d. Homes that employ the use of fuel-fired stoves shall provide adequate railings or other approved protection designed to prevent residents from coming into contact with the stove surfaces; (7-1-99)T
- e. Each resident's sleeping room shall be provided with an openable window which shall not be less than ten percent (10%) of the total floor space in the room. The window sill height shall not be greater than forty-four (44) inches above the finished floor. Window openings shall not be less than twenty-two (22) inches in width and height. Waivers will be considered on a case-by-base basis (refer to Section 004, Waivers); (7-1-99)T
- f. Quantities of flammable and/or highly combustible materials deemed hazardous by the certifying agency shall not be stored in the home; (7-1-99)T
- g. Boilers, hot water heaters, and unfired pressure vessels shall be equipped with automatic pressure relief valves; (7-1-99)T
- h. Portable fire extinguishers shall be installed throughout the home according to the configuration of the home. All extinguishers installed after July 1, 1999 shall be multipurpose ABC type and subject to the approval of the certifying agency; (7-1-99)T
- i. Electrical installations and equipment shall comply with the applicable local and/or state electrical codes; (7-1-99)T
- j. Solid fuel heating devices installed shall be approved by the local fire/building jurisdiction. In addition, openings in all solid fuel heating devices shall be provided with a door(s) constructed of heat tempered glass or other approved material; (7-1-99)T
- k. Furnishings, decorations, or other objects shall not obstruct exits; (7-1-99)T
- l. No door in the path of travel to an exit and any exit door shall be less than twenty-eight (28) inches wide; and (7-1-99)T
- m. Every bathroom shall be designed to permit the opening of the locked door from the outside in case of an emergency. (7-1-99)T
- 03. Smoking.** Because smoking has been acknowledged to be a fire hazard, a continuous effort shall be made to reduce its presence in the home. The certified family home shall observe at least the following: (7-1-99)T
- a. Smoking is prohibited in any area where flammable liquids, gases, or oxidizers are in use and/or stored; (7-1-99)T
- b. Residents shall not be permitted to smoke in bed; (7-1-99)T
- c. Unsupervised smoking is prohibited by residents classified as not mentally or physically responsible. This includes residents so affected by medication; and (7-1-99)T
- d. Nothing in Subsection 600.03 requires that smoking be permitted in homes whose admission policies prohibit smoking. (7-1-99)T

04. Disaster And Fire Preparedness. Each certified family home shall develop and implement an evacuation plan which shall be reviewed with residents upon admission and every six (6) months thereafter. In addition documentation shall be available at each home indicating that all residents have been advised of actions required under emergency conditions. This information shall be maintained in each resident's individual file. (7-1-99)T

05. Report Of Fire. A separate report on each fire incident occurring within the home shall be submitted to the Department within thirty (30) calendar days of the occurrence. The reporting form, "Certified Family Home Incident Report," shall be issued by the Department to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries, if any. (7-1-99)T

06. Maintenance Of Equipment. The home shall assure that all equipment is properly maintained to assure the safety of the residents. (7-1-99)T

a. The smoke detectors shall be tested at least monthly and a written record of the test results maintained on file; (7-1-99)T

b. Portable fire extinguishers shall be serviced annually by an outside servicing agency. In addition, portable fire extinguishers shall be examined, at least quarterly, by a knowledgeable family member to determine that; (7-1-99)T

i. The extinguisher is in its designated location; (7-1-99)T

ii. Seals or tamper indicators are not broken; (7-1-99)T

iii. The extinguisher has not been physically damaged; (7-1-99)T

iv. The extinguisher does not have any obvious defects; and (7-1-99)T

v. Inspecting tags on each extinguisher shall show at least the initials of the person making the quarterly examinations and the date of the examinations. (7-1-99)T

c. Fuel-fired heating systems shall be inspected, serviced, and approved at least annually by person(s) professionally engaged in the business of servicing these systems. The inspection records shall be maintained on file in the home. (7-1-99)T

601. -- 699. (RESERVED).

700. HOME CONSTRUCTION AND PHYSICAL HOME STANDARDS.

01. General Requirements. (7-1-99)T

a. All buildings utilized as certified family homes shall be of such character as to be suitable for such use. Certified family homes shall not be housed in buildings intended for other than residential living purposes; (7-1-99)T

b. Remodeling or additions to homes shall be consistent with residential use of the property and shall not detract from the residential use of the property. Remodeling which identifies the home as a certified family home is prohibited such as remodeling garages when this is not the general practice in the neighborhood or constructing large buildings which overwhelm the lot on which the home is located; and (7-1-99)T

c. All homes shall be subject to the approval of the Department. (7-1-99)T

02. Walls And Floors. Walls and floors shall be of such character to permit frequent cleaning. Walls in residents' sleeping rooms shall extend from floor to ceiling and shall be of such character as to stop the passage of smoke and to provide the resident with privacy. (7-1-99)T

03. Telephone. There shall be a telephone in the home which is accessible to all residents. The telephone shall be situated in such a manner as to provide the resident adequate privacy while using the telephone for private calls. The telephone shall be made immediately available in case of an emergency. Emergency numbers shall be posted near the telephone. (7-1-99)T

- 04. Toilet Facilities And Bathrooms.** Each certified family home shall provide: (7-1-99)T
- a. At least one (1) flush toilet, one (1) tub or shower, and one (1) lavatory with a mirror; (7-1-99)T
 - b. Toilet facilities and bathrooms shall be separated from all rooms by solid walls or partitions; (7-1-99)T
 - c. All inside toilet facilities and/or bathrooms shall have forced ventilation to the outside; (7-1-99)T
 - d. Tubs, showers, and lavatories shall be connected to hot and cold running water; and (7-1-99)T
 - e. Toilet facilities and bathrooms for resident use shall be so arranged that it is not necessary for an individual to pass through another resident's room to reach the toilet or bath. (7-1-99)T

05. Accessibility For Persons With Mobility And Sensory Impairments. For residents with mobility or sensory impairments, the home shall provide a physical environment which meets the needs of the person for independent mobility and use of appliances, bathroom facilities, and living areas. New construction must meet the Americans with Disabilities Act Accessibility Guidelines (ADAAG) requirements. Existing homes shall comply, to the maximum extent feasible with Title III-4.4000 of the Americans with Disabilities Act, without creating an undue hardship or burden on the home, and shall provide as required, the necessary accommodations: (7-1-99)T

- a. Ramps for residents who require assistance with ambulation shall comply with the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.8; and (7-1-99)T
- b. Bathrooms and doors large enough to allow the easy passage of a wheelchair as provided for in the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.13; and (7-1-99)T
- c. Grab bars in resident toilet facilities and bathrooms that comply with the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.26; and (7-1-99)T
- d. Toilet facilities that comply with the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.16 and 4.23; and (7-1-99)T
- e. Non-retractable faucet handles that comply with the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.19 (with the exception of self-closing valves under 4.19.5) and 4.27; and (7-1-99)T
- f. Suitable hand railing shall be provided on both sides of all stairs leading into and out of a building for residents who require the use of crutches, walkers, or braces. (7-1-99)T

06. Furnishings And Equipment. Room and board, assistance with activities of daily living, supervision, assistance with and monitoring of medications, linen, towels, wash cloths, a reasonable supply of soap, shampoo, toilet paper, sanitary napkins, first aid supplies, electric razors or other means of shaving, toothpaste, laundering of linens owned by the home, emergency transportation, housekeeping service, maintenance, utilities, and basic television in common areas shall be included in the basic room and board charges and must be available at no extra charge. In addition, the following shall apply: (7-1-99)T

- a. Resident living rooms shall be provided with reading lamps, tables, and comfortable chairs and/or sofas; (7-1-99)T
- b. Each resident shall be provided with his own bed which shall be at least thirty-six (36) inches wide, substantially constructed, and in good repair. Roll-away type beds, cots, folding beds, or double bunks shall not be utilized. Each bed shall be provided with springs which are in good repair, a clean and comfortable mattress which is standard for the bed, and a pillow; (7-1-99)T
- c. Each sleeping room shall be equipped with individual storage for personal items for each resident; (7-1-99)T

d. Adequate and satisfactory equipment and supplies shall be provided to serve the residents. The amount and kind shall vary according to the size of the home and type of resident; and (7-1-99)T

e. A two-way intercom shall be provided when the size or design of the building necessitates a need for such a system. (7-1-99)T

07. Storage Areas. Adequate storage shall be provided in addition to the required storage in resident sleeping rooms. (7-1-99)T

08. Lighting. Adequate lighting shall be provided in all resident sleeping rooms, dining/living/recreation rooms, and halls. (7-1-99)T

09. Ventilation. The home shall be ventilated, and precautions shall be taken to prevent offensive odors. (7-1-99)T

10. Heating. The temperature within the certified family home shall be maintained at seventy (70) degrees Fahrenheit or more during waking hours when residents are at home and sixty-five (65) degrees Fahrenheit or more during sleeping hours or as defined in the Negotiated Service Agreement. Wood stoves shall not be the primary source of heat and the thermostat for the primary source of heat shall be remotely located away from the wood stove. (7-1-99)T

11. Plumbing. All plumbing in the home shall comply with local and/or state codes. All plumbing fixtures shall be easily cleanable and maintained in good repair. (7-1-99)T

12. Resident Sleeping Rooms. (7-1-99)T

a. Resident sleeping rooms shall not be in attics, stairs, halls, or any rooms commonly used for other than bedroom purposes. Resident sleeping rooms may be in basements only if the following conditions are met: (7-1-99)T

i. The window must not open into a window well that cannot be exited, and the window must provide an adequate view of the outdoors. All other fire and life safety requirements for windows must be met; (7-1-99)T

ii. The basement must have floors, ceilings, and walls which are finished to the same degree as the rest of the home. The sleeping room must meet all other requirements of these rules; and (7-1-99)T

iii. The resident must be assessed through the Negotiated Service Agreement to be capable of evacuating from the basement without assistance in an emergency. (7-1-99)T

b. Resident sleeping rooms shall be provided with walls that run from floor to ceiling and with solid doors that will stop the passage of smoke and provide the resident with adequate privacy; (7-1-99)T

c. Residents shall not occupy the same bedroom as the certified family home provider or their minor age children; (7-1-99)T

d. Ceiling heights in sleeping rooms shall be at least seven feet six inches (7'6"); (7-1-99)T

e. If closet space is utilized by two (2) residents, it shall be provided with substantial dividers for separation of each resident's clothing. All closets shall be equipped with doors. Free-standing closets shall be deducted from the square footage in the sleeping room; (7-1-99)T

f. Homes shall provide sleeping rooms which allow for not less than one-hundred (100) square feet of floor space per resident in a single-bed sleeping room and not less than eighty (80) square feet of floor space per resident in a two (2) person sleeping room. (7-1-99)T

701. -- 709. (RESERVED).

710. REQUIREMENTS FOR EXISTING HOMES TO BE CONVERTED TO CERTIFIED FAMILY HOMES.

In addition to Subsections 700.01 through 700.12, homes to be converted to certified family homes shall comply with the following: (7-1-99)T

- 01. Site Requirements.** The home location shall be: (7-1-99)T
- a. In a lawfully constituted fire district; and (7-1-99)T
 - b. Served by an all-weather road kept open to motor vehicles at all times of the year; and (7-1-99)T
 - c. Accessible to physician or emergency medical services within thirty (30) minutes driving time; and (7-1-99)T
 - d. Accessible within thirty (30) minutes driving time to necessary social, medical, and rehabilitation services. (7-1-99)T

02. Use Of Modular (i.e., Factory Built) Buildings And Manufactured Homes. Modular Buildings as defined in Section 39-4105, Idaho Code, must conform to the requirements of the Uniform Building Code unless approved for use as a home prior to July 1, 1999, and may continue to be certified when evaluated on a case-by-case basis for fire and life safety issues for the current owner. Manufactured Homes as defined in Section 39-4105, Idaho Code, shall not be used unless approved for use as a home prior to July 1, 1999, and may continue to be certified when evaluated on a case-by-case basis for fire and life safety issues for the current owner.

03. Occupancy Approval. Any building proposed for conversion to a home shall be approved by the certifying agency prior to issuance of a certificate. Any items of noncompliance shall be corrected prior to issuance of the certificate. (7-1-99)T

711. -- 724. (RESERVED).

725. ENFORCEMENT PROCESS.

01. Remedies. If the Department finds that a home does not or did not meet a rule governing certified family homes, it may impose the following remedies, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal: (7-1-99)T

- a. Ban on all admissions (See Subsection 726); (7-1-99)T
- b. Ban on admissions of residents with certain diagnosis (See Section 727); (7-1-99)T
- c. Civil monetary penalties (Refer to IDAPA 16.03.22, "Rules for Licensed Residential and Assisted Living Facilities in Idaho," Section 927); (7-1-99)T
- d. Summarily suspend the certificate and transfer residents (See Section 728); (7-1-99)T
- e. Issue a provisional certificate (Refer to IDAPA 16.03.22, "Rules for Licensed Residential and Assisted Living Facilities in Idaho," Section 930); or (7-1-99)T
- f. Revoke the home's certificate (See Section 729). (7-1-99)T

02. Recommendation Of Remedy. In determining which remedy to recommend, the certifying agency shall consider the home's compliance history, change of ownership, the number of deficiencies, scope, and severity of the deficiencies. Subject to these considerations, the Department may impose any of the remedies described in Subsections 725.01.a. through 725.01.f. (7-1-99)T

03. Immediate Jeopardy. If the certifying agency finds that the home's deficiency or deficiencies immediately jeopardize the health or safety of its residents, the Department shall summarily suspend the home's

certificate. (7-1-99)T

04. No Immediate Jeopardy. If the certifying agency finds that the home's deficiency or deficiencies do not immediately jeopardize resident health or safety, the Department may impose one (1) or more of the remedies specified in Subsection 725.01.a. through 725.01.f. (7-1-99)T

05. Repeated Noncompliance. If the certifying agency makes a determination of repeated noncompliance with respect to a home, the certifying agency may impose any of the remedies listed in Subsections 725.01.a. through 725.01.f. The certifying agency shall monitor the home on-site on an as needed basis, until the home has demonstrated to the certifying agency's satisfaction that it is in compliance with all program requirements governing homes and that it will remain in compliance. (7-1-99)T

06. Failure To Comply. If a home has not complied with any program requirement within three (3) months of the date the home is found to have been out of compliance with such requirement, or as stated in the home's accepted plan of correction and the Department has verified, via on-site resurveys, that the home has made little or no progress in correcting deficiencies then the Department shall institute a revocation action against the home. (7-1-99)T

726. ENFORCEMENT REMEDY OF BAN ON ALL ADMISSIONS.

The certifying agency shall notify the home via certified mail banning all admissions to the home pending satisfactory correction of all deficiencies. Such bans to the home or to any part thereof shall remain in effect until the state certifying agency determines that the home has achieved full compliance with all program requirements, or until a substitute remedy is imposed. (7-1-99)T

727. ENFORCEMENT REMEDY OF BAN ON ADMISSIONS OF RESIDENTS WITH SPECIFIC DIAGNOSIS.

The certifying agency shall notify the home via certified mail banning admission of all residents with a specific diagnosis. Such bans may be imposed for all prospective residents both state and private, and shall prevent the home from admitting the kinds of residents for whom it has shown an inability to provide adequate care. (7-1-99)T

728. ENFORCEMENT REMEDY OF SUMMARY SUSPENSION AND TRANSFER OF RESIDENTS.

01. Summarily Suspend The Home's Certificate And Transfer Residents. The certifying agency may summarily suspend a home's certificate and transfer residents when convinced by a preponderance of the evidence that residents' health and safety are in immediate jeopardy. See Subsection 150.05 and Section 184. (7-1-99)T

02. Emergency Powers Of The Director. In the event of an emergency endangering the life or safety of a resident, the Director may summarily suspend or revoke any home certificate. As soon thereafter as practicable, the Director shall provide an opportunity for a hearing. (7-1-99)T

729. ENFORCEMENT REMEDY OF REVOCATION OF CERTIFICATE.

01. Revocation Of The Home's Certificate. The Department may institute a revocation action when persuaded by a preponderance of the evidence that the home is not in substantial compliance with this chapter. (7-1-99)T

02. Causes For Revocation Of The Certificate. The certifying agency may revoke any certificate to include the following causes, but not be limited to: (7-1-99)T

a. The certificate holder has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; (7-1-99)T

b. The home is not in substantial compliance with these rules; (7-1-99)T

c. When persuaded by a preponderance of the evidence that such conditions exist which endanger the health or safety of any resident; (7-1-99)T

- d. Any act adversely affecting the welfare of residents is being permitted, aided, performed, or abetted by the person or persons in charge of the home. Such acts may include, but are not limited to, neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; (7-1-99)T
- e. The provider has demonstrated or exhibited a lack of sound judgment essential to the operation and management of a home; (7-1-99)T
- f. The provider has violated any of the conditions of a provisional certificate; (7-1-99)T
- g. The home has one (1) or more major deficiencies. A major deficiency is a deficiency that endangers the health, safety, or welfare of any resident; (7-1-99)T
- h. An accumulation of minor violations that, taken as a whole would constitute a major deficiency as noted in Subsection 010.50; (7-1-99)T
- i. Repeat violations of any requirement of these rules or of the Idaho Code; (7-1-99)T
- j. The home lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of residents residing at the home; and (7-1-99)T
- k. Substantial Compliance. The home is not in substantial compliance with the provisions for services or residents' rights outlined in Subsection 101.01.d. and Section 200 through Subsection 200.03. (7-1-99)T
- l. Certificate holder refuses to allow the certifying agency and/or Protection and Advocacy agencies full access to the home environment, home records, and/or the residents. (7-1-99)T

03. Additional Causes For Revocation Of Certificate. Additional causes for revocation of a certificate may include the following: (7-1-99)T

- a. Any condition exists in the home which endangers the health or safety of any resident; (7-1-99)T
- b. The provider has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; (7-1-99)T
- c. The provider has demonstrated or exhibited a lack of sound judgment essential to the operation and management of a certified family home; (7-1-99)T
- d. Any deficiency that endangers the health or safety or welfare of any resident; or (7-1-99)T
- e. The home lacks adequate supervision of residents; (7-1-99)T

730. ENFORCEMENT REMEDY OF INJUNCTION.

Notwithstanding any other remedy at law, the Director may seek an injunction in the name of the state against any person or governmental unit to enjoin the establishment, conduct, management, or operation of a certified family home in violation of the provisions of this chapter. See Sections 39-3358, 39-3558, 39-3380, and 39-3570, Idaho Code. (7-1-99)T

731. RIGHT TO SELL.

Nothing contained in Section 725 shall limit the right of any home owner to sell, lease, mortgage, or close any home in accordance with all applicable laws. (7-1-99)T

732. NOTICE OF ENFORCEMENT REMEDY.

The Department shall give notice of the imposition of any remedy described in this chapter after the home is afforded any allowable reviews or hearings as follows: (7-1-99)T

- 01. Notice To Home.** The Department shall give notice to the home in writing, transmitted in a manner

which shall reasonably ensure timely receipt by the home such as certified mail or personal carrier; and (7-1-99)T

02. Notice To Public. The Department shall give notice to the public by transmitting printed notices to the home. The home shall post all notices reasonably expected to be readable by the home's residents or their representatives, including, but not limited to, exits and common areas. The notices shall remain in place until all remedies are officially removed by the certifying agency; and (7-1-99)T

03. Notice To The Ombudsman. The Department shall give notice to the state Ombudsman for the elderly; and (7-1-99)T

04. Notice To The Residents' Attending Physicians. The Department shall give notice to the attending physician of each resident affected by a finding of substandard quality of care; and (7-1-99)T

05. Notice To The Professional Licensing Boards. The Department shall give notice to professional licensing boards, as appropriate; and (7-1-99)T

06. Failure To Effect Notice. Failure of the Department to effect notice as required in Sections 951 through 951.06 of the rules, IDAPA 16.03.22, "Rules For Licensed Residential and Assisted Living Facilities In Idaho," shall not be grounds for the home to contest any action taken under this chapter. (7-1-99)T

733. PROCEDURE FOR HEARINGS FOR ENFORCEMENT ACTIONS AGAINST A CERTIFICATE.

01. Home Notification. Immediately upon the decision to implement an enforcement action to include denial of certificate, the certifying agency shall notify the applicant or provider in writing by certified mail or by personal service of its decision to implement an enforcement action against the certificate and the reason for the enforcement action. (7-1-99)T

02. Administrative Review. The notification of denial or revocation shall also offer the applicant or the provider the opportunity to request an administrative review. Should the home wish to contest imposition of a remedy, other than a plan of correction and except as provided in IDAPA 16.03.22, "Rules for Licensed Residential and Assisted Living Facilities in Idaho," Subsections 927.05 and 928.04, a written request for administrative review must be received by the certifying agency within fourteen (14) calendar days of the home's receipt of notice of imposition of the remedy. The request shall state the grounds for its contention that the imposition of a remedy is in error. (7-1-99)T

a. During this administrative review, the position of the Department and the home may be discussed and if possible an alternative to revocation or denial developed. (7-1-99)T

b. The Department shall transmit printed notice of administrative review. Such notices shall set forth date, time, and location whenever the home has requested and been granted a review on imposition of a remedy. The home shall post all notices so provided. The notices shall be placed in areas readily accessible and visible to residents and their representatives. (7-1-99)T

c. The Department shall issue a written decision within fourteen (14) calendar days of the completion of the home's receipt of the administrative review. The review shall be made solely on the basis of the certifying agency recommendation, the survey report, the statement of deficiencies, any documentation the home submits to the Department at the time of its request, and information received as a result of the administrative review process. For the purposes of such review, a hearing shall not be held and oral testimony shall not be taken. (7-1-99)T

d. If the home fails to file a timely request, the decision to impose a remedy or remedies shall become final and no further hearing or judicial review shall be available. (7-1-99)T

03. Administrative Hearing. Should the home wish to appeal the administrative review decision for remedies described in Section 725 subject to the limitations therein, it may request an administrative hearing in accordance with the provisions of IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings and Declaratory Rulings," Section 301, et seq. The scope of the administrative hearing shall be limited to issues raised and meaningfully addressed in the administrative review. (7-1-99)T

734. TRANSFER OF RESIDENTS.

The Department may transfer residents from a home to an alternative placement on the following grounds: (7-1-99)T

01. Violation Of Rules. As a result of a violation of a provision of the rules or standards, the home's is unable or unwilling to provide an adequate level of meals, lodging, personal assistance, or supervision to persons residing in the home at the time of the violation; (7-1-99)T

02. Violation Of Resident's Rights. A violation of a resident's rights provided in Sections 39-3316, 39-3387, 39-3516, 39-3576, or a combination, Idaho Code; and (7-1-99)T

03. Imminent Danger. A violation of a provision of this chapter or applicable rules or standards results in conditions that present an imminent danger. (7-1-99)T

735. -- 995. (RESERVED).

996. ADMINISTRATIVE PROVISIONS.

Contested case appeals shall be governed by IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings and Declaratory Rulings," Section 300. (7-1-99)T

997. CONFIDENTIALITY OF RECORDS.

Any disclosure of information obtained by the Department is subject to the restrictions contained in IDAPA 16.05.01, "Rules Governing the Protection and Disclosure of Department Records". (7-1-99)T

998. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.21 - RULES FOR RESIDENTIAL CARE FACILITIES IN IDAHO

DOCKET NO. 16-0321-9601

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2000 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 39-3305, Idaho Code.

DESCRIPTIVE SUMMARY: The pending rules are being adopted as proposed. The original text of the proposed rules was published in the August 7, 1996 Administrative Bulletin, Volume 96-8, page 161.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact John Hathaway at (208) 364-1863.

DATED this 21st day of June, 1999.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 334-5548 fax

IDAPA 16
TITLE 03
Chapter 21

RULES FOR RESIDENTIAL CARE FACILITIES IN IDAHO

This Rule Is Being Repealed In Its Entirety.

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho
Administrative Bulletin, Volume 96-8, August 7, 1996, page 161.**

**This rule has been adopted as Final by the Agency
and is now pending review by the
2000 Idaho State Legislature for final adoption.**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.22 - RULES FOR RESIDENTIAL CARE FACILITIES IN IDAHO
DOCKET NO. 16-0322-9602
NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2000 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 39-3505, Idaho Code.

DESCRIPTIVE SUMMARY: The pending rules are being adopted as proposed. The original text of the proposed rules was published in the August 7, 1996 Administrative Bulletin, Volume 96-8, pages 162.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact John Hathaway at (208) 334-6626.

DATED this 21st day of June, 1999

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IDAPA 16
TITLE 03
Chapter 22

RULES FOR RESIDENTIAL CARE FACILITIES IN IDAHO

This Rule Is Being Repealed In Its Entirety.

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho
Administrative Bulletin, Volume 96-8, August 7, 1996, page 162.**

**This rule has been adopted as Final by the Agency
and is now pending review by the
2000 Idaho State Legislature for final adoption.**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.22 - RULES FOR RESIDENTIAL CARE FACILITIES IN IDAHO
DOCKET NO. 16-0322-9603
NOTICE OF RESCISSION OF TEMPORARY RULE

AUTHORITY: In compliance with Section 67-5221 and 67-5226, Idaho Code, notice is hereby given that this agency has rescinded the temporary rulemaking previously adopted under this docket. The action is authorized pursuant to Section(s) 39-3300, 39-3500, and House Bill 742 adopted by the 1996 Idaho Legislature, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a summary of the reasons for the vacation:

This temporary rule is being rescinded and rewritten in Docket No. 16-0322-9901 and Docket No. 16-0319-9901.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this rescission of the temporary rule, contact John Hathaway at (208) 334-6626.

DATED this 21st day of June, 1999

Sherri Kovach
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IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.22 - RULES FOR RESIDENTIAL CARE FACILITIES IN IDAHO
DOCKET NO. 16-0322-9603
NOTICE OF VACATION OF RULEMAKING

AUTHORITY: In compliance with Section 67-5221, Idaho Code, notice is hereby given that this agency has vacated the rulemaking previously initiated under this docket. The action is authorized pursuant to Section(s) 39-3300, 39-3500, and House Bill 742 adopted by the 1996 Idaho Legislature, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a summary of the reasons for the vacation:

This docket is being vacated and re-written in Docket No. 16-0322-9901 and Docket No. 16-0319-9901.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this vacation of the proposed rulemaking, contact John Hathaway at (208) 334-6626.

DATED this 21st day of June, 1999.

Sherri Kovach
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IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.22 - RULES FOR LICENSED RESIDENTIAL AND ASSISTED LIVING FACILITIES IN IDAHO
DOCKET NO. 16-0322-9901

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 1999.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 39-3505 and 39-3525(2), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking and in conjunction with IDAPA 16.03.19, "Rules Governing Certified Family Homes," Docket No. 16-0319-9901, will be held as follows:

August 11, 1999, at 7:00 pm
Coeur d'Alene Inn, Hayden Room
414 West Appleway Ave., Coeur d'Alene, Idaho

August 18, 1999, at 7:00 pm
Ameritel Inn, Pebble Creek Room
1440 Bench Rd., Pocatello, Idaho

August 23, 1999, at 7:00 pm
Ameritel Inn, Tablerock Room
7965 W. Emerald, Boise, Idaho

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The 1996 Legislature passed H.B. 742 which amended the Idaho Board and Care Act and the Residential Care for the Elderly Act. Among other items it required that anyone who provided care commercially to the elderly or individuals with a physical disability, mental illness, or developmental disability to meet at a minimum the requirements of the adult foster care or residential care rules depending upon the size of the facility. This includes adult foster care homes, 1501 homes, personal care services homes, specialized family homes, and residential care facilities.

In the past, each of these types of facilities operated with differing minimum requirements for safety, supervision, and care. The Department of Health and Welfare believes that a better approach is to develop one common set of standards for all residential facilities which must be licensed regardless of program type.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to protect the public health, safety, or welfare and to comply with deadlines in amendments to governing law or federal programs.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

In accordance with the authority granted the Department of Health and Welfare in Sections 39-3505 and 39-3525(2), Idaho Code, these rules will require potential facilities to pay a building evaluation fee to determine if the building chosen to be the facility's physical plant meets the requirements prior to being licensed.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact John Hathaway at (208) 364-1863.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 25, 1999.

DATED this 21st day of June, 1999.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
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(208) 334-5564 phone, (208) 334-5548 fax

THE FOLLOWING IS TEXT OF DOCKET NO. 16-0322-9901

IDAPA 16
TITLE 03
Chapter 22

16.03.22 - RULES FOR LICENSED RESIDENTIAL AND ASSISTED LIVING FACILITIES IN IDAHO

000. LEGAL AUTHORITY.

Pursuant to Sections 39-3305, 39-3371, 39-3505, and 39-3561, Idaho Code, the Idaho Board of Health and Welfare is authorized to adopt and enforce rules and standards designed to protect the health, safety, and individual resident's rights and to ensure the provision of adequate nutrition, supervision, meaningful life activities, and therapeutic recreational activities for residents being served in residential care facilities. (7-1-99)T

001. TITLE AND SCOPE.

The purpose of a licensed residential and assisted living facility in Idaho is to provide a humane, safe, and home-like living arrangement for individuals with a mental illness, developmental disability, physical disability, or who are elderly. The facilities shall be operated and staffed by individuals who have the knowledge and experience required to provide safe and appropriate services to all residents of the facility. The administrators shall protect the rights and provide appropriate services to meet the needs of the individual residents as determined by the uniform assessment instrument and the negotiated service agreement for both state clients and private pay residents. The state will encourage the development of facilities tailored to the needs of individual populations which operate in integrated settings in communities where sufficient supportive services exist to provide the resident, if appropriate, an opportunity to work and be involved in recreation and education opportunities alongside people who do not have a mental illness, developmental disability, physical disability, or who are not elderly. The licensing agency shall be responsible for monitoring and enforcing the provisions of this chapter. This responsibility includes, but is not limited to, licensing facilities, monitoring the condition of the facility administering a uniform assessment instrument for state clients, and taking enforcement actions. Nothing in this chapter is intended to reduce or eliminate any duty of the Department or any other public or private entity for provision of services for any resident. (7-1-99)T

002. (RESERVED).

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by the provision of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (7-1-99)T

004. EXEMPTIONS.

The provisions of these rules do not apply to any of the following: (7-1-99)T

01. Health Facility. The provisions of these rules do not apply to hospitals, nursing facilities, intermediate care facilities for mentally retarded persons, or any other health facility as defined by Title 39, Chapter 13, Idaho Code. (7-1-99)T

02. Alternate Living Arrangements. The provisions of these rules do not apply to any house, institution, hotel, congregate housing project, retirement home, or other similar place that is limited to providing one (1) or more of the following: housing, meals, transportation, housekeeping, or recreational and social activities, or that have residents independently accessing supportive services from an entity approved to provide such services in Idaho and holding no legal ownership interest in the entity operating the facility. (7-1-99)T

03. Relatives. The provisions of these rules do not apply to any arrangement for the receiving and care of persons by a relative, except when the caretaker is paid for the care through a state or federal program, in which case the caretaker relative and the care setting must meet the requirements of the program that funds the care. (7-1-99)T

04. Similar. The provisions of these rules do not apply to any facility exempted by the Director. (7-1-99)T

005. WAIVERS.

Waivers may be granted by the Department provided the following criteria are met: (7-1-99)T

01. Written Request. A written request for waiver must be sent to the licensing agency. The request must include, but is not limited to, the following: (7-1-99)T

a. Reference to the section of the rules for which the waiver is requested; (7-1-99)T

b. Reasons that show good cause why the waiver should be granted, the extenuating circumstances which caused the need for the waiver, any compensating factors or conditions that may have bearing on the waiver such as additional floor space or additional staffing; and (7-1-99)T

c. Written documentation that assures residents' health and safety will not be jeopardized if the waiver is granted. (7-1-99)T

02. Temporary Waivers. A temporary waiver may be granted for up to one (1) year. (7-1-99)T

03. Continuing Temporary Waivers. The appropriateness of continuing a waiver shall be reviewed by the licensing agency during the annual survey. If the facility administrator wishes to continue the waiver, an annual request must be submitted to the Department in writing. (7-1-99)T

04. Permanent Waiver. A permanent waiver may be granted provided the provisions of Subsections 005.01.a. through 005.01.c. are met. (7-1-99)T

05. Decision To Grant A Variance. The decision to grant a waiver shall not be considered as precedent or be given any force or effect in any other proceeding. (7-1-99)T

006. SERVICES.

Supportive services shall be provided according to the resident's individual negotiated service agreement. (7-1-99)T

007. POLICY.

Many of the residents of facilities are unable to assess situations or respond quickly to emergencies. The residents' safety is dependent upon properly designed and constructed buildings with provisions for the prevention and detection of fires to include alarm and extinguishment systems. Individuals who understand operating and maintenance procedures are essential. The residents' welfare is dependent upon care, attention, motivation, and advice

delivered at the proper time by skilled people. Every person or organization operating a facility must take responsibility for the safety and well-being of those in their care. (7-1-99)T

008. INCORPORATION BY REFERENCE.

All documents referenced herein shall constitute the full adoption by reference of those documents as provided by Section 67-5229 (a), Idaho Code. (7-1-99)T

01. Documents Incorporated. The following documents are incorporated in these rules: (7-1-99)T

a. National Fire Protection Association (NFPA), Life Safety Code, National Standards Council, 1981 and 1988 Editions; (7-1-99)T

b. National Fire Protection Association (NFPA), National Fire Code, Volumes 1 -- 11, 1990 Edition; (7-1-99)T

c. National Fire Protection Association, NFPA 101M, 1988 Edition, Manual on Alternative Approaches to Fire Safety; (7-1-99)T

d. Uniform Building Code, International Conference of Building Officials, 1988 Edition; (7-1-99)T

e. Idaho Diet Manual, Idaho Dietetic Association, Eighth Edition 1998; (7-1-99)T

f. IDAPA 16.02.19, "Rules Governing Food Safety and Sanitation Standards For Food Establishments (UNICODE)," July 1, 1998; (7-1-99)T

g. Administrative Rules of the Idaho State Board of Nursing, IDAPA 23.01.01, "Rules of the Board of Nursing"; and (7-1-99)T

h. Americans with Disabilities Act Accessibility Guidelines, 28 CFR Part 36, Appendix A. (7-1-99)T

02. Availability Of Documents. The incorporated documents are available for public review at the following locations: (7-1-99)T

a. Administrative Procedures Section, Department of Health and Welfare, 450 West State Street, 10th Floor, P.O. Box 83720, Boise Idaho, 83720-0036 or the licensing agency. (7-1-99)T

b. Idaho Supreme Court Law Library, 451 West State Street, Boise, Idaho, 83720. (7-1-99)T

009. (RESERVED).

010. DEFINITIONS.

01. Abuse. The non-accidental infliction of physical pain, injury, or mental injury. (7-1-99)T

02. Activities. All organized and directed social and rehabilitative services a facility provides, arranges, or cooperates with. (7-1-99)T

03. Activities Of Daily Living. The performance of basic self-care activities in meeting an individual's needs to sustain him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communicating, continence, managing money, mobility, and associated tasks. (7-1-99)T

04. Adequate Care. Services provided to the resident as described in his negotiated service agreement and within accepted standards of practice. (7-1-99)T

05. Administrator. The person who has primary responsibility for the day-to-day administration of the facility with three (3) or more residents and is employed as a full-time administrator and licensed by the state of Idaho. The administrator and legal owner may not necessarily be the same individual. A full-time administrator shall

devote no less than twenty (20) hours a week to the day-to-day administration of the facility. The Department will consider a waiver based on an approved plan of administration and operation by the facility. (7-1-99)T

06. Adult. A person who has attained the age of eighteen (18) years. (7-1-99)T

07. Advanced Directive. A written instruction, such as a living will or durable power of attorney for health care, recognized under State Law, whether statutory or as recognized by the courts of the State, and relates to the provision of medical care when the individual is unable to communicate. (7-1-99)T

08. Advocate. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of a population group served by a facility. (7-1-99)T

09. Alzheimer's Disease And Related Dementia. A progressive, degenerative, terminal disease that attacks the brain and results in impaired memory, thinking, and behavior. The person may experience memory loss, confusion, personality, and behavior changes, impaired judgment, difficulty finding words, finishing thoughts, following directions, and difficulty with other cognitive efforts. (7-1-99)T

10. Ambulatory Person. A person who, unaided by any other person, is physically and mentally capable of walking a normal path to safety, including the ascent and descent of stairs. (7-1-99)T

11. Assessment. The conclusions reached using uniform criteria developed by the Department and relevant councils for determining a person's need for care and services. (7-1-99)T

12. Basement. Any floor level below the first story in a building except that a floor level in a building having only one (1) floor level shall be classified as a basement. (7-1-99)T

13. Behavioral Management. A written program which actively builds and develops new or alternative styles of independent functioning and promotes new behavior which results in the highest potential level of self-sufficiency. (7-1-99)T

14. Care And Supervision. The provision by the facility of one (1) or more of the following services: (7-1-99)T

a. Assisting the resident with activities of daily living; (7-1-99)T

b. Arranging for supportive services; (7-1-99)T

c. Being aware of the resident's general whereabouts; (7-1-99)T

d. Monitoring the activities of the resident while on the premises of the facility to ensure the resident's health, safety, and well-being; and (7-1-99)T

e. Assisting residents with self-administration of medication. (7-1-99)T

15. Chemical Restraint. The use of any medication that results or is intended to result in the modification of behavior. (7-1-99)T

16. Client Of The Department. Any person who receives financial aid, or services, or both from an organized program of the Department. (7-1-99)T

17. Complaint Investigation. A survey or visit to determine the validity of allegations of resident abuse, neglect, misappropriation of resident property, or of other noncompliance with applicable state requirements. (7-1-99)T

18. Criminal Offense. Any crime as defined in Section 18-111, Idaho Code, in 18 U.S.C. Section 4A1.2(o), and 18 U.S.C. Sections 1001 through 1027. (7-1-99)T

19. **Deficiency.** A determination of non-compliance with a specific rule or part of a rule. (7-1-99)T
20. **Department.** The Idaho Department of Health and Welfare. (7-1-99)T
21. **Developmental Disability.** A developmental disability, as defined in Section 66-402, Idaho Code, means chronic disability of a person which appears before the age of twenty-two (22) years of age and: (7-1-99)T
- a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism, or other conditions found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and (7-1-99)T
- b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and (7-1-99)T
- c. Reflects the need for a combination and sequence of special, interdisciplinary or direct care, treatment or other services which are of life-long or extended duration and individually planned and coordinated. (7-1-99)T
22. **Director.** The Director of the Idaho Department of Health and Welfare or his designee. (7-1-99)T
23. **Elderly.** A person sixty-five (65) years or older who does not have a primary diagnosis of mental illness, or developmental disability, or both, and who does not require active treatment. (7-1-99)T
24. **Exploitation.** An action which may include, but is not limited to, the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage. (7-1-99)T
25. **Finding.** A determination resulting from a survey or complaint investigation of the facility that a potential compliance issue is present, and could, or should have been prevented, or has not yet been identified by the facility, is not being corrected by proper action by the facility, or cannot be justified by special circumstances unique to the facility or the resident. A finding may or may not be cited as a deficiency based upon the scope and severity of the noncompliance. (7-1-99)T
26. **Follow-Up Survey.** A survey conducted to verify corrections of deficiencies cited during the previous survey. (7-1-99)T
27. **Full License.** A one (1) year license issued by the licensing agency of the Department to a facility complying with this chapter. (7-1-99)T
28. **Functional Abilities Assessment.** An assessment of the resident's physical, mental, emotional, and social abilities to cope with the affairs and activities of daily living. (7-1-99)T
29. **Governmental Unit.** The state, any county, municipality, or other political subdivision or any department, division, board, or other agency thereof. (7-1-99)T
30. **Hands On.** Physical assistance to the resident beyond verbal prompting. (7-1-99)T
31. **Hourly Adult Care.** Nonresident daily services and supervision provided by a facility to individuals who are in need of supervision outside of their personal residence for a portion of the day. (7-1-99)T
32. **Immediate Jeopardy.** The licensing agency has determined that residents are subject to an imminent or substantial danger. (7-1-99)T
33. **Independent Mobility.** A resident's ability to move about freely of their own choice with or without the assistance of a mobility device such as a wheelchair, cane, crutches, or walker. (7-1-99)T
34. **Individual Support Plan.** The written individualized plan approved by the Department, which

must be based on a person-centered planning and assessment process outlining the consumers' needs, desires, goals, and objectives, and include the specific types, amounts, frequency, and duration of waiver services to be provided by the agency. (7-1-99)T

35. Initial Deficiency. The first time that a deficiency or deficiencies are recorded by a surveyor as the result of a survey or complaint investigation. Initial deficiency may be records of deficiencies that occurred prior to the date of the survey visit even if the deficiencies no longer exist at the time of the current survey. (7-1-99)T

36. Legal Guardian/Conservator. A court-appointed individual who manages the affairs or finances or both of another who has been found to be incapable of handling his own affairs. (7-1-99)T

37. Level Of Care. This is based on a categorical assessment of the resident's functional ability and the intensity (degree) of care required in the areas of activities of daily living, supervision, response to emergency situations, mobility, medications, and behavior management. (7-1-99)T

38. Level I - Minimal Assistance. The resident requires room, board, and supervision and may require one (1) or more of the following: (7-1-99)T

- a. Minimal assistance with activities of daily living and nonmedical personal assistance. (7-1-99)T
- b. Minimal assistance with mobility -- the resident is independently mobile. (7-1-99)T
- c. Minimal assistance in an emergency -- the resident is capable of self-preservation in an emergency. (7-1-99)T
- d. Minimal assistance with medications -- the resident does not require medication management or supervision. (7-1-99)T
- e. Minimal behavior management substantiated by the resident's history. (7-1-99)T

39. Level II - Moderate Assistance. The resident requires room, board, and supervision and may require one (1) or more of the following: (7-1-99)T

- a. Moderate assistance with activities of daily living and nonmedical personal assistance. (7-1-99)T
- b. Moderate assistance with mobility but easily mobile with assistance. (7-1-99)T
- c. Moderate assistance in an emergency but resident is capable of self-preservation with assistance. (7-1-99)T
- d. Moderate assistance with medications. (7-1-99)T
- e. Moderate assistance with behavior management. (7-1-99)T

40. Level III - Extensive Assistance. The resident requires room, board, supervision, and requires staff up and awake on a twenty-four (24) basis and may require one (1) or more of the following: (7-1-99)T

- a. Extensive assistance with activities of daily living. (7-1-99)T
- b. Extensive personal assistance. (7-1-99)T
- c. Extensive assistance with mobility and may be non-mobile without extensive assistance. (7-1-99)T
- d. Extensive assistance in an emergency and may be incapable of self-preservation without assistance. (7-1-99)T
- e. Extensive assistance with and monitoring of medications. (7-1-99)T

- f. Extensive assistance with training or behavior management or both. (7-1-99)T
- 41. License.** A permit to operate a facility. (7-1-99)T
- 42. Licensee.** The holder of a license to operate a facility under this chapter. (7-1-99)T
- 43. Licensed Environmental Health Specialist.** A person trained and experienced in physical, biological, chemical, and social and sanitary sciences and who is licensed by the Idaho State Bureau of Occupational Licenses. (7-1-99)T
- 44. Licensing Agency.** The unit of the Department of Health and Welfare that conducts inspections and surveys and issues licenses based on compliance with this chapter. (7-1-99)T
- 45. Medication.** Any substance or drug used to treat a disease, condition, or symptom, which may be taken orally, injected, or used externally and is available through prescription or over-the-counter. (7-1-99)T
- 46. Medication Administration.** The issuance of one or more doses of prescribed medication to an individual. (7-1-99)T
- 47. Medication Assistance.** Assistance to a resident in taking his medication including reminding the resident to take medication, removing a medication container from storage, assisting with the removal of the cap, assisting with the removal of a medication from a container for residents with a disability which prevents independence in this act, and observing the resident taking the medication. (7-1-99)T
- 48. Medication Dispensing.** Medication dispensing is the issuance of a medication in its original container with a pharmacy label bearing the instructions ordered by the prescriber. (7-1-99)T
- 49. Mentally III.** A person with one (1) or more of the following: (7-1-99)T
- a. A significant disorder of thought, mood perception, orientation, or memory which impairs judgment, behavior, and capacity to recognize and adapt to reality; (7-1-99)T
- b. Over a period of time has demonstrated marginal social adjustment which prevents him from living independently in the community; (7-1-99)T
- c. Manifested difficulties in social or personal adjustment associated with psychiatric disability, as demonstrated in reduced, lost, or underdeveloped capacities relative to: (7-1-99)T
- i. Personal relationships; (7-1-99)T
- ii. Living arrangements; (7-1-99)T
- iii. Work; (7-1-99)T
- iv. Recreation; (7-1-99)T
- v. Personal care; (7-1-99)T
- vi. Community living skills; or (7-1-99)T
- vii. Other primary aspects of daily living. (7-1-99)T
- 50. Monitoring Visit.** A visit by a representative of the Department for the purpose of verifying a facility's correction of deficiencies, or to observe the orderly transfer of residents, during a facility's closure. (7-1-99)T

- 51. Neglect.** The negligent failure to provide those goods or services which are reasonably necessary to sustain the life and health of a person pursuant to Section 39-5302(8), Idaho Code. (7-1-99)T
- 52. Negotiated Service Agreement.** The agreement reached by the resident and their representative and the facility based on the assessment, physician's orders, if any, admission records, if any, and desires of the resident, and which outlines services to be provided and the obligations of the facility and the resident. (7-1-99)T
- 53. Owner.** Any entity, governmental unit, or person having legal ownership of the facility. (7-1-99)T
- 54. Personal Assistance.** The provision by the staff of the facility of one (1) or more of the following services: (7-1-99)T
- a. Assisting the resident with activities of daily living. (7-1-99)T
 - b. Arranging for supportive services. (7-1-99)T
 - c. Being aware of the resident's general whereabouts and supervision as required in the resident's negotiated service agreement. (7-1-99)T
 - d. Monitoring the activities of the resident while on the premises of the facility to ensure the resident's health, safety, and well-being. (7-1-99)T
 - e. Assisting residents with self-administration of medication. (7-1-99)T
- 55. Personnel.** Paid or unpaid individuals assigned with the responsibility of oversight of the facility. (7-1-99)T
- 56. Physical Restraint.** Any device or physical force that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body. Excluded are physical guidance and prompting techniques of brief duration. (7-1-99)T
- 57. PRN.** A medication or treatment prescribed by a medical professional to an individual allowing the medication to be given as needed. (7-1-99)T
- 58. Pressure Ulcers.** Localized areas of cellular necrosis, pressure ulcers occur most often in the skin and subcutaneous tissue over bony prominence, particularly the sacrum, ischial tuberosities, great trochanter, heels, malleoli, and elbows. (7-1-99)T
- 59. Provisional License.** A license which may be granted to a facility which is not in compliance with the rules but which has no deficiencies that would endanger the health or safety of the residents, pending the satisfactory correction of all deficiencies. (7-1-99)T
- 60. Psychosocial History.** A combined summary of psychological and social histories of an individual designed to inform a care giver of a person's strengths, weaknesses, and potential problems. (7-1-99)T
- 61. Publicly Funded Programs.** Any program funded in whole or in part by an appropriation of the U.S. Congress, the Idaho Legislature, or a county commission. (7-1-99)T
- 62. Punishment.** Any procedure in which an adverse consequence is presented to a resident that is designed to produce a decrease in the rate, intensity, duration or probability of the occurrence of a behavior; or the administration of any noxious or unpleasant stimulus or deprivation of a resident's rights or freedom for the purpose of reducing the rate, intensity, duration, or probability of a particular behavior. (7-1-99)T
- 63. Relative(s).** Persons related by birth, adoption, or marriage to the first degree and grand parent and grand child. (7-1-99)T
- 64. Repeat Deficiency.** A violation or deficiency found on a resurvey or revisit that was also found on

the previous survey or visit. (7-1-99)T

65. Repeated Noncompliance. A finding of substandard quality of care on three (3) consecutive surveys, or visits, or both. (7-1-99)T

66. Representative Of The Department. An employee of the Department or a designee of the Department. (7-1-99)T

67. Resident, Boarding Home. An individual who lives and functions independently and is responsible for making his own decisions. (7-1-99)T

68. Residential And Assisted Living Facility. One (1) or more buildings constituting a facility or residence, however named, operated on either a profit or nonprofit basis, for the purpose of providing twenty-four (24) hour care for three (3) or more adults who need personal care or assistance and supervision essential for sustaining activities of daily living or for the protection of the individual. In this chapter Licensed Residential and Assisted Living Facilities shall be referred to as "facility". It is the same entity defined in Sections 39-3302(29) and 39-3502(29), Idaho Code. Distinct segments of a facility may be licensed separately, provided each segment meets all applicable rules. (7-1-99)T

69. Resident, Residential And Assisted Living Facility. All occupants of a facility other than the owner, administrator, their immediate families, or employees. (7-1-99)T

70. Room And Board. Lodging and meals. (7-1-99)T

71. Scope. The frequency, incidence, or extent of the occurrence of a deficiency in a facility. (7-1-99)T

72. Self-Administration Of Medication. The act of a resident taking a single dose of his own medication from a properly labeled container and placing it internally in, or externally on, his own body as a result of an order by a physician and dentist. (7-1-99)T

73. Self Preservation. An individual's ongoing ability to execute actions necessary to safeguard against personal harm, injury, or accident. (7-1-99)T

74. Service Plan. The Negotiated Service Agreement, Personal Care Plan, Plan of Care, or Individual Support Plan. (7-1-99)T

75. Severity. The seriousness of a deficiency, which means the degree of actual or potential negative impact on a resident (as measured by negative outcomes or rights violations) or the degree to which his highest practicable physical, mental, or psychosocial well-being has been compromised. (7-1-99)T

76. Story. That portion of a building included between the upper surface of any floor and the upper surface of the floor next above, except that the topmost story shall be that portion of a building included between the upper surface of the topmost floor and the ceiling or floor above. If the finished floor level directly above a basement or unused under-floor space is more than six (6) feet above grade as defined herein for more than fifty percent (50%) of the total perimeter or is more than twelve (12) feet above grade as defined herein at any point, such basement or unused under-floor space shall be a story. (7-1-99)T

77. Story, First. The lowest story in the building which qualifies as a story, as defined herein, except that a floor level in a building having only one (1) floor level shall be classified as a first story, provided such floor level is not more than four (4) feet below grade, as defined herein, for more than fifty percent (50%) of the total perimeter, or more than eight (8) feet below grade, as defined herein, at any point. (7-1-99)T

78. Substandard Quality Of Care. A finding by the licensing agency of one (1) or more deficiencies, the existence of which limit(s) the facility's ability to deliver adequate care or services. (7-1-99)T

79. Substantial Compliance. A facility is in substantial compliance with these rules when there are no deficiencies which endanger the health, safety, or welfare of the residents. (7-1-99)T

80. Supervision. Administrative activity which provides protection, guidance, knowledge of the resident's whereabouts, and assistance with activities of daily living. The administrator is responsible for providing appropriate supervision based on each resident's negotiated service agreement. (7-1-99)T

81. Supportive Services. The specific services that are provided to the resident in the community and that are required by the negotiated service agreement or reasonably requested by the resident. (7-1-99)T

82. Survey. An on-site review conducted by a surveyor to determine compliance in the areas of quality of care, rehabilitative care, resident rights, administrative services, dietary and nutrition services, activities, social participation, sanitation, infection control, and physical environment. (7-1-99)T

83. Surveyor. A person authorized by the Department to conduct surveys or complaint investigations to determine compliance with program requirements. (7-1-99)T

84. Temporary License. A license, not to exceed six (6) months in duration, which shall be issued to a facility upon compliance with the initial application process. The purpose of the temporary license is to give the Department time to determine the facility's ongoing capability to provide services and to meet rules. (7-1-99)T

85. Trust Account. Accounts maintained by the facility separate from its own accounts, to deposit, hold, or disburse monies belonging to residents. The facility shall be the trustee of such accounts and the residents shall be the beneficiaries. (7-1-99)T

86. Uniform Assessment Instrument. A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities pursuant to IDAPA 16.03.23, "Rules Governing Uniform Assessments for State-Funded Clients". (7-1-99)T

87. Waiver Services. Home and Community Based (HCBS) Services. (7-1-99)T

88. 1501 Home. A home as authorized by Section 39-3561(9) of the Idaho Code, to provide care and supervision for up to four (4) adults. Certification as a 1501 home is not transferable to another person or location other than as originally certified. Homes certified under this provision shall not be subject to the licensed residential care facility administrator or facility licensing requirements of Title 54, Chapter 42, Idaho Code, or Title 39, Chapters 33 and 35, Idaho Code. With the exception of the limitation on numbers of residents, 1501 homes are subject to all rules regarding certified family homes in Idaho. (7-1-99)T

011. -- 100. (RESERVED).

101. GENERAL REQUIREMENTS FOR A LICENSE.

01. Current Valid License. After July 1, 1996, no person, firm, partnership, association or corporation within the state, and no governmental unit shall operate, establish, manage, conduct, or maintain a facility for individuals with a mental illness, developmental disability, physical disability, the elderly, or a combination of resident populations, in the State without a current valid license issued by the Department. (7-1-99)T

02. Application. Any person or governmental unit proposing to operate a facility for individuals with a mental illness, developmental disability, physical disability, the elderly, or a combination of resident populations shall apply for a license to the licensing agency specifying the types of residents to be served and the level of care to be provided. (7-1-99)T

03. Distinctive Name. Every facility shall use a distinctive name in applying for a license, and the name shall not be changed without first notifying the Department in writing at least thirty (30) calendar days prior to the date that the proposed name change is to be effective. (7-1-99)T

04. General Condition Of Licensure. As a general condition of licensure, the following goods or services shall be provided to the resident as part of the base charge: (7-1-99)T

- a. Appropriate, adequate supervision as outlined in the resident's negotiated service agreement; and (7-1-99)T
- b. Room and board; and (7-1-99)T
- c. Furnishings and equipment as outlined in Section 550; and (7-1-99)T
- d. Staffing; and (7-1-99)T
- e. Negotiated service agreement development and implementation; and (7-1-99)T
- f. Provision for arrangement of reasonable transportation to community activities, recreational, religious activities, or a combination of activities. (7-1-99)T

05. Department Access. Each facility, all buildings associated with its operation and all records required under these rules shall be accessible at all times to the Department for the purposes of inspection, with or without prior notification. (7-1-99)T

06. Issuance To Person And Address. A license to operate a facility shall be issued specifically in the name of the applicant applying for a license, and only to the address of the facility stated in the application. (7-1-99)T

102. APPLICATIONS.

01. Initial License. The owner/applicant shall apply for a license on forms provided by the Department giving such information as the Department shall require including, but not limited to: (7-1-99)T

a. A written statement that the applicant has thoroughly read and reviewed this chapter and is prepared to comply with all provisions of IDAPA 16.03.22, "Rules for Licensed Residential and Assisted Living Facilities in Idaho"; (7-1-99)T

b. Satisfactory evidence that the applicant is of reputable and responsible character to include a criminal history check as provided in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". A criminal history check must be repeated every three (3) years. If the applicant is unable to obtain an acceptable criminal record clearance, the Department shall deny the application; (7-1-99)T

c. A signed resume including a chronological employment history covering the last five (5) years; (7-1-99)T

d. Four (4) character references, two (2) of which must be provided by professional licensed individuals, including addresses and telephone numbers. Character references may not include relatives; (7-1-99)T

e. The applicant must provide a written statement that discloses any license revocation or other disciplinary action taken or in the process of being taken, against a license held or previously held by the entities in Idaho as specified in Section 39-3345 or 39-3545 or both, Idaho Code, or any other jurisdiction, or that verifies that the applicant has never been involved in any such action; (7-1-99)T

f. A statement must be provided which indicates that the applicant has completed the Department approved orientation; (7-1-99)T

g. If the owner/applicant is not the administrator, then the administrator shall meet the requirements of Subsections 102.01 through 102.01.f., 102.01.p., and 102.01.q.; (7-1-99)T

h. If the owner/applicant is a firm, association, organization, partnership, business trust, corporation, or company, the administrator or other members of the organization who will provide direct resident care or who will directly influence the facility shall provide the information contained in Subsections 102.01.a. through 102.01.g. Each shareholder/investor holding ten percent (10%) or more interest in the firm shall be listed on the application;

- (7-1-99)T
- i. Evidence of liability insurance sufficient to cover claims against the facility; (7-1-99)T
 - j. A statement from the local fire authority that the facility is located in a lawfully constituted fire district or affirmation that a lawfully constituted fire authority will respond to a fire at the facility; (7-1-99)T
 - k. The building shall be required to meet all applicable requirements of local, state, and national codes, including current electrical and plumbing requirements; (7-1-99)T
 - l. A statement from a licensed electrician or the local/state electrical inspector that all wiring in the facility complies with applicable local codes. A copy of the statement shall be kept on file at the facility; (7-1-99)T
 - m. If the facility is not utilizing an approved municipal water or sewage treatment system, a statement from a local environmental health specialist indicating that the water supply and sewage disposal system meet the requirements of the Department. The reports shall be kept on file at the facility, and shall be kept current; (7-1-99)T
 - n. Completed application form signed by the applicant; (7-1-99)T
 - o. A complete set of operational policies and procedures which meets the requirements of these rules. (7-1-99)T
 - p. Licensed Administrator Requirements. If the owner/applicant is not the administrator, only the administrator is required to be licensed as an Idaho Residential Care Administrator. (7-1-99)T
 - q. Administrator's License. A copy of the Idaho Residential Care Administrator's license, or evidence that the administrator is currently in the process of obtaining a license, must be provided with the application. (7-1-99)T
 - r. Facility Floor Plan. A rough sketch detailing the floor plan of the facility, including measurement of all rooms, or a copy of professionally prepared blueprints shall be submitted for evaluation by the Department (see Sections 526 and 527). (7-1-99)T

02. Building Evaluation Fee. The application must be accompanied by a five hundred dollar (\$500) initial building evaluation fee. (7-1-99)T

03. Written Request For Building Evaluation. The applicant must provide a written request for a building evaluation for existing buildings, which includes the address of the building that is to be evaluated; the level of care of the residents for whom the building is being evaluated to serve; and the name, address, and telephone number of the person who is to receive the building evaluation report completed by the Department. (7-1-99)T

04. Failure Of The Applicant To Cooperate With The Licensing Agency In The Completion Of The Application Process Shall Result In The Denial Of The Application. Failure to cooperate means that the information described in this section of the rules has not been provided, or not provided in the form requested by the licensing agency, or both. This application process cannot exceed six (6) months. (7-1-99)T

103. CHANGE OF OWNERSHIP.

01. Nontransferability Of License. Licenses are not transferable from one (1) individual to another or from one (1) lessee to another or from one (1) location to another. When a change of ownership, lease, or location occurs, the facility must be relicensed, and the new operator must follow the application procedures described above. (7-1-99)T

02. Application For Change Of Ownership. The application for a change of ownership must be submitted to the licensing agency at least sixty (60) days prior to the proposed date of change. (7-1-99)T

03. Change Of Ownership For A Leased Facility In Litigation. An application for change of

ownership of a facility that is being leased from a person who is in litigation for failure to meet licensure standards, or who has had his license revoked, shall include evidence that there is a bonafide arms length agreement and relationship between the two (2) parties. See Subsection 111.02.h. (7-1-99)T

104. -- 110. (RESERVED).

111. DENIAL OF LICENSE.

01. Endangerment Of Resident's Health And Safety. The Department may deny the issuance of a license when conditions exist that endanger the health or safety of any resident. (7-1-99)T

02. Substantial Compliance With These Rules. The licensing agency may deny the issuance of a license when the facility is not in substantial compliance with these rules. Additional causes for denial of a license may include the following: (7-1-99)T

a. The applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license; or (7-1-99)T

b. The applicant has been guilty of fraud, gross negligence, abuse, assault, battery, or exploitation with respect to the operation of a health facility or residential care facility or certified family home; or (7-1-99)T

c. The applicant is actively affected in his performance by alcohol or the use of drugs classified as controlled substances; or (7-1-99)T

d. The applicant is of poor moral and responsible character or has been convicted of a felony or defrauding the government; or (7-1-99)T

e. The applicant has been denied or the applicant's wrongdoing has caused the revocation of the license/certificate of any health facility, residential and assisted living facility, or certified family home; or (7-1-99)T

f. The applicant has been convicted of operating any health facility or residential care facility without a license or certified family home without a certificate; or (7-1-99)T

g. The applicant is directly under the control or influence of any person who has been subject to the proceedings described in Subsection 111.02.c.; or (7-1-99)T

h. The applicant is directly under the control or influence of any person who is of poor moral and responsible character or has been convicted of a felony or defrauding the government. (7-1-99)T

112. EFFECT OF PREVIOUS REVOCATION OR DENIAL OF A LICENSE.

The licensing agency is not required to review the application of an applicant who has had a license denied until five (5) years have elapsed from the date of license denial or appeal. (7-1-99)T

113. -- 124. (RESERVED).

125. LICENSE REQUIREMENTS.

01. Person And Premises. Each license issued shall be only for the premises and persons named in the application and shall not be transferable or assignable; (7-1-99)T

02. Number Of Beds And Residents. Each license shall specify the maximum allowable number of beds and residents to be housed. All occupants other than the owner, administrator, immediate family, or employees shall be included in the licensed bed capacity; and (7-1-99)T

03. Display Of License. The license shall be posted in the facility, clearly visible to the general public. (7-1-99)T

126. TYPE OF LICENSE.

01. Temporary License. Following completion of an acceptable application, the final inspection, approval of the building by the licensing agency, and after determining that the facility has the initial capability to provide services, the facility shall be issued a temporary license, not to exceed six (6) months. Within the six (6) month period, the licensing agency shall conduct a full survey to determine the facility's ongoing capability to provide services. (7-1-99)T

a. The temporary license may be replaced with a full license prior to the expiration of the temporary license, when the licensing agency has completed a revisit and has determined that the facility qualifies for a full license; or (7-1-99)T

b. During the period of the temporary license, if the licensing agency determines that the facility is not in compliance with the provisions of these rules, facility shall be denied a full license and the temporary license shall be revoked. (7-1-99)T

02. Full License. A full license shall be valid for a period of time not to exceed twelve (12) months from the date of issuance. The license shall expire at the end of its stated period unless it is extended by the licensing agency or by operation of law. (7-1-99)T

03. Provisional License. Facilities found to be in substantial compliance with these rules but which fail to comply in every detail may be issued a provisional license, when failure to comply will not adversely affect the health and safety of the residents. A license issued on the basis of substantial compliance is contingent upon the correction of deficiencies in accordance with an agreed upon plan. (7-1-99)T

a. Provisional licenses may be issued for up to six (6) months, and only to facilities that are fully licensed at the time the provisional license is issued. (7-1-99)T

b. A provisional license will not be issued to a facility operating under a temporary license. (7-1-99)T

127. EXPIRATION AND RENEWAL OF LICENSE.

01. Application For License Renewal. The application for renewal of a license shall be submitted on a form prescribed by the Department. The completed application shall be returned to the Department at least sixty (60) days prior to the expiration of the existing license. (7-1-99)T

02. Existing License. The existing license, unless suspended or revoked, shall remain in force and effect until the licensing agency has acted upon the application renewal, when such application for renewal is timely filed. (7-1-99)T

128. -- 135. (RESERVED).

136. STATE LICENSING TO SUPERSEDE LOCAL REGULATION.

These rules and standards shall supersede any program of any political subdivision of the state which licenses or sets standards for facilities. (7-1-99)T

137. -- 149. (RESERVED).

150. ENFORCEMENT PROCESS.

01. Remedies. If the Department finds that a facility does not or did not meet a rule governing licensed residential and assisted living facilities, it may impose the following remedies, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal: (7-1-99)T

a. Ban on all admissions, see Section 925; (7-1-99)T

b. Ban on admissions of residents with certain diagnosis, see Section 926; (7-1-99)T

- c. Civil monetary penalties, see Section 927; (7-1-99)T
- d. Appointment of temporary management, see Section 928; (7-1-99)T
- e. Summary suspension of the license, or transfer residents, or both, see Section 929 and 971; (7-1-99)T
- f. Issuance of a provisional license, see Section 930; or (7-1-99)T
- g. Revocation of the facility's license, see Section 931. (7-1-99)T

151. -- 169. (RESERVED).

170. UNLICENSED FACILITIES.

01. Unlicensed Facility. An operation shall be considered an unlicensed facility if it meets the definition of a facility stated in these rules, or is represented to provide care and serve the population of a residential and assisted living facility, is not licensed, and is not exempt from licensure. (7-1-99)T

02. Residents In Unlicensed Facilities. Upon discovery of an unlicensed facility, the Department shall refer residents to appropriate placement or adult protective services agency if either of the following conditions exist: (7-1-99)T

- a. There is an immediate threat to the resident's health and safety; or (7-1-99)T
- b. The unlicensed facility does not cooperate with the licensing agency to apply for a license, meet licensing standards and obtain a license. (7-1-99)T

03. Operator Of An Unlicensed Facility. A person found to be operating a facility without a license shall be guilty of a misdemeanor punishable by imprisonment in a county jail not to exceed six (6) months, or by a fine not to exceed five thousand dollars (\$5,000), pursuant to Section 39-3352(4), Idaho Code. (7-1-99)T

04. Prosecution Of Violators. In the event the county attorney in the county where the alleged violation occurred fails or refuses to act within thirty (30) days of notification of the violation, the Attorney General is authorized to prosecute violations under the provisions of Section 39-3352(5), Idaho Code. (7-1-99)T

05. Placement Of Persons Into An Unlicensed Facility. No person shall place, refer, or recommend placement of a person into a facility which is operating without a license. To do so shall constitute a misdemeanor, pursuant to Section 39-3353, Idaho Code. (7-1-99)T

171. -- 180. (RESERVED).

181. INSPECTIONS.

01. Inspection Of Facilities. The licensing agency shall cause to be made such inspections and investigations, based on previous survey results, as it may deem necessary to determine compliance with this chapter and applicable rules and standards. (7-1-99)T

02. Unannounced Inspections. For licensed facilities, with the exception of initial surveys, all inspections and investigations will be made unannounced and without prior notice. (7-1-99)T

03. Inspection Services. The licensing agency may utilize the services of any legally qualified person or organization, either public or private, to examine and inspect any entity requesting a facility license. (7-1-99)T

04. Access And Authority. An inspector shall have full access and authority to examine among other things, quality of care, services delivery, resident records, facility's records including any records or documents

pertaining to any financial transactions between residents and the facility or any of its employees, resident accounts, physical premises, including the condition of buildings, grounds and equipment, food service, water supply, sanitation, maintenance, housekeeping practices, and any other areas necessary to determine compliance with applicable rules and standards. (7-1-99)T

05. Interview Authority. An inspector shall have the authority to interview the license holder, administrator, staff, residents, residents' families, or other legally responsible person. Interviews with residents shall be confidential and conducted privately unless otherwise specified by the resident. (7-1-99)T

06. Access To The Entire Facility. The inspector shall have full authority to inspect the entire facility, including personal living quarters of operators, administrator, or staff living in the facility, to check for inappropriate storage of combustibles, faulty wiring, or other conditions that may have a direct impact on the compliance with these rules. (7-1-99)T

07. Written Report. Following any investigation or inspection, the licensing agency shall provide within a reasonable period of time, a written report to the administrator of the facility. The report shall include the finding of the investigation or inspection. (7-1-99)T

08. Statement Of Deficiencies. If deficiencies are identified during the investigation or inspection, the facility shall be sent a statement of deficiencies which requires a plan of correction. (7-1-99)T

09. Plan Of Correction. An acceptable plan of correction must include how the deficiency was corrected or how it shall be corrected, what steps have been taken to assure that the deficiency does not recur, and acceptable time frames for correction of the deficiency. (7-1-99)T

10. Submit Plan Of Correction. The facility shall be given a reasonable period of time to develop a plan of correction and to return the plan of correction to the licensing agency. (7-1-99)T

11. Follow-Up Surveys. Follow-up surveys may be conducted to ascertain if corrections to deficiencies are being made according to time frames established in the plan of correction. (7-1-99)T

182. -- 190. (RESERVED).

191. COMPLAINTS.

01. Filing A Complaint. A person who believes that any provision of these rules has been violated may file a complaint with the Department. (7-1-99)T

02. Investigations. The licensing agency shall investigate, or cause to be investigated, any complaint alleging a violation of these rules. (7-1-99)T

03. Disclosure Of Complaint Information. The Department will not disclose the name or identifying characteristics of a complainant unless: (7-1-99)T

a. The complainant consents in writing to the disclosure; (7-1-99)T

b. The investigation results in a judicial proceeding and disclosure is ordered by the court; or (7-1-99)T

c. The disclosure is essential to prosecution of a violation. The complainant shall be given the opportunity to withdraw the complaint before disclosure. (7-1-99)T

04. Method Of Investigation. The nature of the complaint shall determine the method used to investigate the complaint. On-site investigations of facilities shall be unannounced. (7-1-99)T

05. Exit Conference. The facility administrator or his designee shall be offered an exit conference, where the findings of the investigation shall be discussed. (7-1-99)T

06. Statement Of Deficiency. If violation of these rules is identified, depending on the severity, the facility shall be sent a statement of deficiencies, shall be required to prepare a plan of correction, and return it to the licensing agency within a time frame designated by the licensing agency. (7-1-99)T

07. Actions. The licensing agency shall inform the complainant or, if requested by the complainant, the complainant's representative, of the results of the investigation and any action to be taken by the facility to resolve the problem. (7-1-99)T

192. PUBLIC DISCLOSURE.

01. Disclosure Of Resident Identity. Information received by the licensing agency through filed reports, inspections, or as otherwise authorized under the law, shall not be disclosed publicly in such a manner as to identify individual residents except as necessary in a proceeding involving a question of licensure. (7-1-99)T

02. Public Availability Of Deficiencies. A current list of deficiencies relating to a facility, including plans of correction, shall be available to the public upon written request to any regional office of the Department or to the licensing agency. (7-1-99)T

193. -- 249. (RESERVED).

250. RESIDENTS' RIGHTS.

Each facility shall develop and implement a written residents' rights policy which shall protect and promote the rights of each resident including, but not limited to, the following: (7-1-99)T

01. Resident Records. Each facility must maintain and keep current a record of the specific information on each resident (refer to Section 426). Upon request a resident shall be provided access to information in his records. (7-1-99)T

02. Privacy. Each resident must be assured the right to privacy with regard to accommodations, medical, and other treatment, written and telephone communications, and visits and meetings of family and resident groups. (7-1-99)T

03. Humane Care And Environment. Each resident shall have the right to humane care and a humane environment including the following: (7-1-99)T

- a. The right to a diet which is consistent with any religious or health-related restrictions; (7-1-99)T
- b. The right to refuse a restricted diet; and (7-1-99)T
- c. The right to a safe and sanitary living environment. (7-1-99)T

04. Dignity And Respect. Each resident shall have the right to be treated with dignity and respect, including: (7-1-99)T

- a. The right to be treated in a courteous manner by staff; (7-1-99)T
- b. The right to receive a response from the facility to any request of the resident within a reasonable time; and (7-1-99)T
- c. The right to be free from intimidation, manipulation, coercion, and exploitation. (7-1-99)T

05. Behavior Management Programs. Each resident shall have the right to be free of unwarranted use of behavior management programs and chemical and physical restraints. (7-1-99)T

06. Habilitation/Training. The resident shall have the right to participate in a habilitation/training program if the resident qualifies for habilitation/training, as determined by an assessment, if he desires to participate,

and if the program is available. (7-1-99)T

07. Participation In The Development Of The Negotiated Service Agreement. Each resident shall have the opportunity to participate in the development of, review of, and changes to his negotiated service agreement. Residents or their legal guardians must be advised of alternative courses of care and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in the development of the negotiated service agreement. (7-1-99)T

08. Personal Possessions. Each resident shall have the right to: (7-1-99)T

- a. Wear his own clothing; (7-1-99)T
- b. Determine his own dress and hair style; (7-1-99)T
- c. Retain and use his own personal property in his own living area so as to maintain individuality and personal dignity; and (7-1-99)T
- d. Be provided a separate storage area in his own living area and at least one (1) locked cabinet or drawer, if the resident is capable of managing lock and key, for keeping personal property. (7-1-99)T

09. Personal Funds. Residents who are clients of the Department shall retain the basic allowance for their personal use. In addition, each client of the Department (Aid to the Aged, Blind, and Disabled (AABD)) is to retain the standard unearned income disregard allowed by the Department. The resident may pay the facility for personal laundry service using the income disregarded by the standard income disregard described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled". The resident is not required to use the facility's laundry service and may retain the disregarded income for their personal use. (7-1-99)T

10. Management Of Personal Funds. A facility shall not require a resident to deposit his personal funds with the facility. If the facility manages resident funds, the facility must account for the personal funds of the resident deposited with the facility as follows: (7-1-99)T

- a. The resident must give the facility written authorization to manage his funds; (7-1-99)T
- b. The facility must assure a full and complete accounting of each resident's personal funds, maintain a written record of all financial transactions involving each resident's personal funds deposited with the facility, and afford the resident, or legal guardian/conservator of the resident, reasonable access to such record; (7-1-99)T
- c. The facility must deposit any amount of a resident's personal funds in excess of one hundred dollars (\$100) in an interest bearing account that is separate from any of the facility's operating accounts, and credit all interest earned on the separate account to the resident account; (7-1-99)T
- d. The facility may maintain any other resident funds in a non-interest bearing account or petty cash fund; (7-1-99)T
- e. The facility must assure that the resident has access to his personal funds during reasonable hours; (7-1-99)T
- f. Upon the death of a resident with such an account who is not a client of the Department, the facility must promptly convey the resident's personal funds, with a final accounting of such funds, to the individual administering the resident's estate; and (7-1-99)T
- g. Upon the death of a resident with such an account who is a client of the Department, the facility must promptly refund the remaining balance of the resident's personal funds, with a final accounting of such funds, to the Department. (7-1-99)T

11. Access And Visitation Rights. Each facility must permit: (7-1-99)T

a. Immediate access to any resident, by any representative of the Department, by the state Ombudsman for the elderly or his designees, by Co-AD or their designees for individuals with a developmental disability or mental illness, by the Idaho Alliance For Mental Illness or their designee for individuals with a mental illness, or by the resident's physician; (7-1-99)T

b. Immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives; (7-1-99)T

c. Immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident; and (7-1-99)T

d. Reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. (7-1-99)T

12. Access By Advocates And Representatives. A facility shall permit advocates and representatives of community legal services program, whose purposes include rendering assistance without charge to residents, to have access to the facility at reasonable times in order to: (7-1-99)T

a. Visit, talk with and make personal, social services programs, and legal services available to all residents; (7-1-99)T

b. Inform residents of their rights and entitlements, their corresponding obligations under state, federal, and local laws by distribution of educational materials or discussion in groups, or with individuals, or both; (7-1-99)T

c. Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance, and social security benefits, as well as in all other matters in which residents are interested. This assistance may be provided individually, or in a group basis, and may include organizational activity, counseling, and litigation; (7-1-99)T

d. Engage in all other methods of assisting, advising, and representing residents so as to extend to them the full enjoyment of their rights; (7-1-99)T

e. Communicate privately and without restrictions with any resident who consents to the communication; and (7-1-99)T

f. Observe all common areas of the facility. (7-1-99)T

13. Posting Of Pertinent Advocacy Groups. The names, addresses, and telephone numbers of all pertinent advocacy groups shall be readily available in the facility for resident access. These groups shall include, but not be limited to: (7-1-99)T

a. The state licensing agency; (7-1-99)T

b. The state Ombudsman for the elderly; (7-1-99)T

c. Co-Ad, Inc., Idaho's Protection and Advocacy System for individuals with a disability; (7-1-99)T

d. Idaho Alliance For Mental Illness for individuals with a mental illness; and (7-1-99)T

e. Adult Protection. (7-1-99)T

14. Employment. Each resident shall have the right to refuse to perform services for the facility except as contracted for by the resident and the administrator of the facility. If the resident is hired by the facility to perform services as an employee of the facility, the wage paid to the resident and withholding shall be consistent with state and federal law. (7-1-99)T

15. **Confidentiality.** Each resident shall have the right to confidentiality of personal and clinical records. (7-1-99)T
16. **Freedom From Abuse.** Each resident shall have the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience. (7-1-99)T
17. **Freedom Of Religion.** Each resident shall have the right to practice the religion of his choice or to abstain from religious practice. Residents shall also be free from the imposition of the religious practices of others. (7-1-99)T
18. **Control And Receipt Of Health Related Services.** Each resident shall have the right to control his receipt of health related services, including: (7-1-99)T
- a. The right to retain any health related services including but not limited to the services of his own personal physician and dentist; (7-1-99)T
 - b. The right to select the pharmacy or pharmacist of his choice; and (7-1-99)T
 - c. The right to confidentiality and privacy concerning his medical condition, dental condition, and treatment. (7-1-99)T
19. **Grievances.** Each resident shall have the right to voice and file a grievance with respect to treatment or care that is furnished, without discrimination or reprisal for voicing the grievance and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. (7-1-99)T
20. **Participation In Resident And Family Groups.** Each resident shall have the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility. (7-1-99)T
21. **Participation In Other Activities.** Each resident shall have the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. (7-1-99)T
22. **Examination Of Survey Results.** Each resident shall have the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Department with respect to the facility and any plan of correction in effect with respect to the facility. (7-1-99)T
23. **Transfer Or Discharge.** Each resident shall have the right to be transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay and in non-emergency conditions is given at least fifteen (15) calendar days advance written notice prior to the date of discharge or transfer or up to thirty (30) calendar days as agreed to in the admission agreement. (7-1-99)T
24. **Other Facilities.** Each resident has a right to review a list of other facilities that may be available to meet his needs. (7-1-99)T
25. **Citizenship Rights.** Each resident has a right to be encouraged and assisted to exercise his rights as a resident and as a citizen, including the right to be informed and to vote. (7-1-99)T
26. **Advanced Directives.** Elderly residents shall have the right to be informed, in writing, regarding the formulation of an advanced directive to include applicable State law. (7-1-99)T
27. **Other Rights.** Each resident shall have any other right established by law. (7-1-99)T
28. **Resident Councils.** Every facility over fifteen (15) beds shall assist the residents in establishing and maintaining a resident council. The council shall be composed of residents of the facility and may include their family members. The council may extend membership to advocates, friends and others. (7-1-99)T

- 29. Council Duties.** The council shall have the following duties: (7-1-99)T
- a. To assist the facility in developing a grievance procedure; (7-1-99)T
 - b. To communicate resident opinions and concerns; (7-1-99)T
 - c. To obtain information from the facility and disseminate the information to the residents; (7-1-99)T
 - d. To identify problems and participate in the resolution of those problems; and (7-1-99)T
 - e. To act as a liaison with the community. (7-1-99)T
- 30. Waiver For Resident Council.** The requirement that every facility over fifteen (15) beds shall assist the residents in establishing and maintaining a resident council may be waived provided the following conditions are met: (7-1-99)T
- a. The operator meets regularly with residents; (7-1-99)T
 - b. Residents decline to participate in a formal council; and (7-1-99)T
 - c. Appropriate documentation exists to indicate the residents' decision. (7-1-99)T
- 251. NOTICE OF RIGHTS.** Notice of Rights. Each facility shall: (7-1-99)T
- 01. Inform Residents Orally And In Writing.** Inform each resident, orally and in writing, at the time of admission to the facility, of his resident rights during the stay at the facility; (7-1-99)T
 - 02. Written Statements.** Make available to each resident, upon request, a written statement of such rights; (7-1-99)T
 - 03. Written Description Of Rights.** The written description of resident rights in Section 250 shall include a description of the protection of personal funds and a statement that a resident may file a complaint with the licensing agency respecting resident abuse, neglect, and misappropriation of resident property in the facility; and (7-1-99)T
 - 04. Copy Of Rights Posted In The Facility.** A copy of the list of resident rights shall be conspicuously posted in the facility at all times. (7-1-99)T
- 252. -- 374. (RESERVED).**
- 375. ADMINISTRATION AND ADMINISTRATOR.** Each facility shall be organized and administered under one (1) authority. (7-1-99)T
- 376. QUALIFICATIONS OF THE ADMINISTRATOR.**
- 01. Qualifications Of The Administrator.** Each facility shall have at least one (1) full-time administrator who: (7-1-99)T
 - a. Has not been convicted of any felony or defrauding of the federal government as verified by a criminal background check (refer to Section 39-5604, Idaho Code); (7-1-99)T
 - b. Has sufficient physical, emotional, and mental capacity to carry out the requirements of the rules as verified by a statement from a licensed physician or nurse practitioner upon assuming duties; (7-1-99)T
 - c. The Department may conduct such investigations as it may deem necessary to determine the

capabilities of an administrator and may request an administrator to provide any additional information it deems necessary related to that person's character and qualifications; and (7-1-99)T

d. The administrator, his relatives, or employees shall not act as or seek to become the legal guardian of, or have power of attorney for any resident, unless a waiver is granted by the Department at the time of each survey on a case-by-case basis considering cases where guardianship is in the best interest of the resident including but not limited to medical necessity, protection from abuse/neglect, or safety and supervision issues of the resident. The administrator may not require the resident to name them as the payee as a condition of providing services. Specific limited powers of attorney to address emergency procedures where competent consent cannot otherwise be obtained are permitted. (7-1-99)T

02. Valid License For Administrator. The administrator shall have a valid residential care administrator's license. (7-1-99)T

377. RESPONSIBILITIES OF THE ADMINISTRATOR.

01. Supervision. The administrator shall provide supervision for all personnel. (7-1-99)T

02. Personnel Background Check. The administrator shall ensure that, prior to or upon hire, a background check is conducted on each employee. (7-1-99)T

03. Sufficient Personnel. The administrator shall have sufficient personnel: (7-1-99)T

a. To assure the safety and proper care of the residents in the facility based upon the physical and mental condition of the residents; (7-1-99)T

b. To assure the safety and proper care of the residents in the facility based on the size and layout of the building, or buildings, or both; (7-1-99)T

c. To assure the safety and proper care of the residents in the facility based on the capabilities and training of the personnel; (7-1-99)T

d. To assure the implementation of emergency procedures, including evacuation of the residents, if required, in accordance with the facility's disaster preparedness plan, in the event of fire, disaster, or other threats pertaining to the health, safety, and security of the residents; and (7-1-99)T

e. To assure the safety and proper care of the residents in the facility based on compliance with this chapter. (7-1-99)T

04. Personnel Job Descriptions For Personal Care To Residents. The administrator shall develop and provide written job descriptions to personnel who are responsible for providing personal care to residents. (7-1-99)T

05. Minimum Age Of Personnel. The administrator shall assure that no personnel providing hands-on care or supervision services shall be under eighteen (18) years of age. (7-1-99)T

06. Assignment Of Duties To Personnel. The administrator shall assign to each employee duties consistent with his level of education, preparation, and experience. (7-1-99)T

07. CPR And First Aid Certification For Personnel On Duty. The administrator shall assure that there is at least one (1) employee within the facility at all times who has a certification in CPR and an approved first aid course. (7-1-99)T

08. Delegation Of Authority. (7-1-99)T

a. When residents are on the premises and require care, the administrator shall not leave the premises without delegating necessary authority to a competent employee who is familiar with the residents and their needs,

emergency procedures, the location and operation of emergency equipment, and how the administrator can be reached in the event of an emergency. (7-1-99)T

- b. When all residents are off site, the administrator or his designee must be reachable in an emergency. (7-1-99)T

09. Personnel With Infections. The administrator shall assure that personnel who have a communicable disease, infectious wound, or other transmittable condition and who provide care or services to residents: (7-1-99)T

- a. Shall be required to implement protective infection control techniques approved by the administrator; (7-1-99)T
- b. Shall not be required to work until the infectious stage is corrected or shall be reassigned to a work area where contact with others is not expected and likelihood of transmission of infection is absent; and (7-1-99)T
- c. Shall take other effective steps to avoid spreading the employee's infection. (7-1-99)T

10. Personnel Training In Infection Control For Universal Precautions. The administrator shall assure that each person employed by the facility, including housekeeping personnel, or contract personnel, or both, who may come into contact with potentially infectious material, are trained in infection control procedures for Universal Precautions. (7-1-99)T

11. Relief Personnel. The administrator shall provide for trained relief personnel to substitute for regular personnel during vacation, illness, or other absences from the facility. (7-1-99)T

12. Notification Of Change In Administrator. Facility owners shall immediately notify the licensing agency, in writing, of a change in a facility's administrator. (7-1-99)T

13. Responsibility For Reports And Records. The administrator shall be responsible for the completion, storage, and submission of such reports and records as may be required by the licensing agency. (7-1-99)T

14. Responsibility For Compliance With Rules. The administrator shall be responsible for compliance with these rules. (7-1-99)T

378. -- 396. (RESERVED).

397. TRAINING OF FACILITY PERSONNEL.

01. Orientation Program. Each facility shall develop and follow a structured written orientation training program designed to meet the training needs of new personnel in relation to responsibilities of the facility to ensure quality of care and compliance with the rules. (7-1-99)T

02. Time Requirements. A minimum of eight (8) hours of job-related orientation training shall be provided to all new personnel before they are allowed to provide unsupervised personal assistance to residents. (7-1-99)T

03. Orientation Training Documentation. Signed evidence of personnel orientation training, indicating hours and topic, shall be retained at the facility. (7-1-99)T

398. PERSONNEL CONTINUING TRAINING.

Personnel Continuing Training Time Requirements. Each employee who provides personal assistance to residents shall receive a minimum of eight (8) hours of job related continuing training per year. Signed evidence of personnel continuing training, indicating hours and topic, shall be retained at the facility. CPR and First Aid certification are not included as part of this eight (8) hour minimum per year. (7-1-99)T

399. PERSONNEL.

- 01. Policies.** Written personnel policies shall be on file and provided to personnel which describe the employees' rights, responsibilities, and employer's expectations. (7-1-99)T
- 02. Job Descriptions.** Each employee shall be provided with a job description outlining authority, responsibilities, and duties. (7-1-99)T
- 03. Personnel Records.** A record for each employee shall be maintained and available. (7-1-99)T

400. STAFFING STANDARDS AND REQUIREMENTS.

- 01. Sufficient Personnel.** The facility shall have sufficient personnel to provide care, during all hours, required in each resident's negotiated service plan. The facility retains the full responsibility of assuring that sufficient personnel is available in the facility at all times to assure residents' health, safety, comfort, and supervision. Residents shall not be left in charge of other residents. (7-1-99)T
- 02. Residents' Sleeping Hours.** There must be as least one (1) staff person immediately available, at the facility, during residents' sleeping hours. (7-1-99)T
- 03. Level III Residents.** In facilities admitting or retaining any Level III residents or a combination of Level I, II, or III, there shall be a minimum of one (1) staff person, in the same building, up and awake during the residents' sleeping hours. (7-1-99)T
- 04. Level III Resident Waiver.** In facilities admitting or retaining any Level III clients or a combination of Level I, II, or III, the supervision requirement that personnel be up and awake on a twenty-four (24) hour basis may be the subject of a request for a waiver or variance pursuant to Section 005. In facilities of fifteen (15) beds or less, if the supervision requirement in each resident's negotiated service agreement states that during residents' sleeping hours personnel up and awake is unnecessary, a request for variance of this requirement will be considered by the Department. (7-1-99)T
- 05. Two Or More Buildings.** In facilities where residents are housed in two (2) or more detached buildings, personnel shall monitor each building on a regular basis. During the residents' sleeping hours, a staff person shall monitor each building at least once an hour. (7-1-99)T
- 06. Additional Personnel.** Additional personnel as identified by the Negotiated Service Agreement and the Universal Assessment Instrument may be required based on the following: (7-1-99)T
- a. The physical and mental condition of the residents; (7-1-99)T
 - b. The configuration and design of the building; and (7-1-99)T
 - c. The location of the facility, both in terms of time and distance, and its proximity to emergency and supportive services. (7-1-99)T
- 07. Staffing Patterns Shall Be Based On Resident Need Rather Than Resident Numbers.** (7-1-99)T
- 08. Level III Resident Waiver.** Personnel up and awake at night shall be required and a waiver or variance will not be granted when a facility has ten (10) or more Level III clients. (7-1-99)T
- 09. Work Records.** Work records shall be maintained in writing which reflect: (7-1-99)T
- a. Personnel on duty, at any given time, for the previous twelve (12) months; and (7-1-99)T
 - b. The first and last names, of each employee, and their position. (7-1-99)T

401. -- 419. (RESERVED).

420. OPERATIONAL STANDARDS AND PROCEDURES.

01. Operational Policies. Each facility shall develop and implement a written set of operational policies; which shall be available at all times and shall include, but not be limited to: (7-1-99)T

a. Appropriate transfer to other facilities for acute medical or other care to include timely transfer when needed; (7-1-99)T

b. Signed release by the resident or legal guardian/conservator for transfer of pertinent information to the receiving facility; (7-1-99)T

c. Arrangements made for emergency medical, dental, or other services; (7-1-99)T

d. Temporary detention of a resident against his will to protect him or others from harm, which shall include how this is to be accomplished, and persons to be notified including the resident's legal guardian/conservator or family, the Department and local law enforcement; (7-1-99)T

e. Maintenance of a log to include documentation indicating any significant change in a resident's physical or mental status and the facility's action or response. A twelve (12) month record of logs shall be maintained in the facility; (7-1-99)T

f. Notification of significant changes in physical or mental condition to the family, legal guardian/conservator, or should there be none, the Department; (7-1-99)T

g. Conditions under which transfer of a resident can be made without prior notification to, or consent of, the family or legal guardian/conservator; (7-1-99)T

h. Assurance that physician's orders are adhered to; (7-1-99)T

i. Death of a resident while in the facility; (7-1-99)T

j. Provision and maintenance of a system of identifying each resident's personal property and methods for safekeeping of his valuables. Each resident's clothing and other property shall be reserved for his own use; (7-1-99)T

k. Provision for the timely return of the resident's valuables and personal purchases at the time of his transfer, discharge, or death; (7-1-99)T

l. Provisions for smoking or non-smoking; (7-1-99)T

m. Provisions for alerting or calling an operator or attendant during the night and permitting any resident to secure the attention of personnel at any time; (7-1-99)T

n. Plans and procedures for the operation of the physical plant, which include, but are not limited to, utilities, fire safety, and plant maintenance; (7-1-99)T

o. Investigations and review of written reports by the administrator of every incident/accident involving a resident; and (7-1-99)T

p. Notification of the resident's family or legal guardian/conservator, or in the case of Department clients, the regional office of the Department, of any unusual happenings to a resident such as accidents, sudden illness, disease, unexplained absence, or death. (7-1-99)T

q. Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, Ombudsman for the elderly, osteopath,

optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, or exploited shall immediately report such information to the Idaho Commission on Aging or its Area Agencies on Aging (Section 39-5303, Idaho Code). (7-1-99)T

r. It is the facility's responsibility to report within four (4) hours to the appropriate law enforcement agency when there is reasonable cause to believe that abuse, neglect, misappropriation of resident's property, or sexual assault has resulted in death or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult resident (refer to Sections 39-5303 and 39-5310, Idaho Code). Failure to report can result in negative action up to and including revocation of the facility's license. (7-1-99)T

02. Resident Medications. There shall be a policy describing the facility's system for handling resident medications in accordance with Section 428 of these rules. (7-1-99)T

03. Behavior Management Programs. If any behavior management is used, there shall be a policy describing the facility's behavior management program which is: (7-1-99)T

- a. Designed and closely monitored to assure that the interventions of the program are positive; (7-1-99)T
- b. The least restrictive and least aversive means of obtaining the desired result; and (7-1-99)T
- c. Must be approved by an individual qualified in resident behavior management and must be approved by the Department if the client is a client of the Department. (7-1-99)T

04. Habilitation/Training. If appropriate, there shall be a policy describing the facility's habilitation/training program which: (7-1-99)T

- a. Is designed to promote optimal independence; (7-1-99)T
- b. Maximize the developmental or independence potential of the resident; and (7-1-99)T
- c. Is provided in the setting that is the least restrictive of the resident's personal liberties. (7-1-99)T

421. INCIDENTS AND COMPLAINTS.

01. Facility Response To Incidents And Complaints. Each facility shall develop and implement a written incident and complaint policy and procedure which shall include, but not be limited to, the following: (7-1-99)T

- a. A method of assuring that the owner, administrator or person designated by the administrator is notified of all incidents or complaints; (7-1-99)T
- b. That the owner, administrator or person designated by the owner or administrator has personally investigated and prepared a written report of finding for each incident or complaint; (7-1-99)T
- c. That the person making the complaint or reporting the incident has received a response of action taken to resolve the matter or a reason why no action needs to be taken; and (7-1-99)T
- d. In the case of an anonymous complaint, the administrator shall document the action taken or a reason why no action needs to be taken. (7-1-99)T

02. Administrator Availability For Complaints. In order to assure the opportunity for complaints from the residents, the neighborhood, and the community to be made directly to the owner, administrator, or person designated by the owner or administrator, each facility shall establish a regular time when the owner, administrator, or person designated by the owner, administrator shall be present to personally respond to such incidents or complaints. (7-1-99)T

03. Log Of Complaints. Each facility shall establish and maintain a separate complaint log that includes a list of all complaints lodged, the name of the person lodging the complaint, the date and time the complaint was lodged, who investigated the complaint, and what actions were taken to resolve the complaint. The complaint log shall be made available for review during visits by the licensing agency. (7-1-99)T

422. ADMISSION POLICIES.

01. Admission Policies. Each facility shall develop and follow a written admission policy. This written description of services provided by the facility to the residents shall be on file and available to the public and shown to any potential resident, his legal guardian/conservator, or both. The written admission policy shall include as a minimum, but not be limited to, the following: (7-1-99)T

- a. The purpose, quantity and characteristics of the service; (7-1-99)T
- b. Any restrictions or conditions imposed on the resident as a result of religious beliefs or philosophy of the owner or administrator, any particular dietary beliefs, or any unusual restrictions or practices or both regardless of the reason; (7-1-99)T
- c. Any limitations concerning delivery of routine personal care by persons of the opposite sex. (7-1-99)T
- d. Placement to Meet the Needs of the Resident. The health, number, age, and sex of children or other adults in the facility shall be taken into account in evaluating the appropriateness of a placement for meeting the needs of an adult. (7-1-99)T

02. Review Prior To Admission. Services offered, charges, and information required of residents shall be reviewed with the potential resident or his legal guardian/conservator prior to admission. (7-1-99)T

03. Fee Description. A written description of how fees shall be handled by the facility for a partial month's care shall be included. (7-1-99)T

04. Notice Of Increase Of Monthly Fee. Resident or resident's legal guardian/conservator shall be notified in writing of an increase in the facility monthly rates at least thirty (30) calendar days prior to such a raise in monthly rates. (7-1-99)T

05. Agreement To Handle Funds. A written agreement whether or not the facility shall accept responsibility for the residents' personal funds shall be available. (7-1-99)T

06. Signed Admission Agreement. The admission agreement must be signed by the resident or his legal guardian/conservator and a representative of the facility. (7-1-99)T

07. Policies Of Acceptable Admissions. Written descriptions of the conditions for admitting residents to the facility shall include but not be limited to: (7-1-99)T

- a. No resident shall be admitted or retained for whom the facility does not have the capability or services to provide appropriate care, or who requires a level of service, or type of service for which the facility is not licensed to provide or which the facility does not provide, or if the facility does not have the personnel, appropriate in numbers and with appropriate skill to provide such services; (7-1-99)T
- b. No resident shall be admitted or retained who requires ongoing skilled nursing, intermediate care, or care not within the legally licensed authority of the facility unless there are specialized facility provisional agreements with the Department that allow for skilled nursing or intermediate care; (7-1-99)T
- c. No resident shall be admitted or retained who requires ongoing highly technical skilled nursing procedures. Limited nursing services will require a nurse on site during the nursing procedure; (7-1-99)T

- d. No resident shall be admitted or retained who requires skilled nursing care on a twenty-four (24) hour basis; (7-1-99)T
- e. No resident shall be admitted or retained with pressure ulcers or open wounds that are not healing; (7-1-99)T
- f. No resident shall be admitted or retained with draining wounds for which the drainage cannot be contained; (7-1-99)T
- g. No resident shall be admitted or retained who is beyond the level of fire safety provided by the facility; and (7-1-99)T
- h. No resident shall be admitted or retained whose physical, emotional, or social needs are not compatible with the other residents in the facility. (7-1-99)T

08. Categories Of Residents. The facility shall notify potential residents of the types of populations it specializes in serving and it will not discriminate on the basis of race, color, national origin, religion, sex or disability. (7-1-99)T

09. Admission Of Residents. The facility shall not admit any residents without a written order by the attending physician or authorization by the Department. (7-1-99)T

10. Short-Term Care Admissions For Fourteen Days Or Less. Facilities may provide care for potential residents that meet regular admission requirements including physician orders for diet, treatment, medications, and an authorized negotiated service agreement. No admission is permitted that places the facility over its licensed bed capacity. (7-1-99)T

423. ADMISSION AGREEMENTS.

01. Admission Agreements. Prior to or on day of admission to the facility, the facility and the resident or the resident's legal guardian/conservator shall enter into an admission agreement. The agreement shall be in writing and shall be signed by both parties. The admission agreement may be integrated with the negotiated service agreement provided that all requirements for the negotiated service agreement and admission agreement are met. The admission agreement shall include at a minimum the following: (7-1-99)T

- a. Services that the facility shall provide including, but not limited to, daily activities, recreational activities, maintenance of self-help skills, assistance with activities of daily living, arrangements for medical and dental services, provisions for trips to social functions, special diets, and arrangements for payments; (7-1-99)T
- b. Whether or not the resident shall assume responsibility for his own medication including reporting missed medication or medication taken on a PRN basis; (7-1-99)T
- c. Whether or not the facility shall accept responsibility for the residents' personal funds; (7-1-99)T
- d. How a partial month's refund shall be handled; (7-1-99)T
- e. Responsibility for valuables belonging to the resident and provision for the return of residents' valuables should the resident leave the facility; (7-1-99)T
- f. Fifteen (15) calendar days' written notice or up to thirty (30) calendar days as agreed to in the admission agreement prior to transfer or discharge on the part of either party; (7-1-99)T
- g. Conditions under which emergency transfers shall be made; (7-1-99)T
- h. Permission to transfer pertinent information from the resident's medical record to an acute care facility, nursing facility, licensed residential and assisted living facility, or certified family home; (7-1-99)T

- i. Resident responsibilities as appropriate; and (7-1-99)T
- j. Other information as may be appropriate. (7-1-99)T
- k. Written documentation of the resident's preference regarding the formulation of an Advance Directive in accordance with Idaho state law. If applicable, a copy of the resident's Advance Directive shall be available. (7-1-99)T

02. Conditions Of Termination Of The Admission Agreement. The admission agreement shall not be terminated except under the following conditions: (7-1-99)T

- a. By written notification by either party giving the other party fifteen (15) calendar days' written notice or up to thirty (30) calendar days as agreed to in the admission agreement; (7-1-99)T
- b. The resident's mental or physical condition deteriorates to a level requiring evaluation, service, or both that cannot be provided in a facility; (7-1-99)T
- c. Nonpayment of the resident's bill; (7-1-99)T
- d. In emergency conditions a resident may be transferred out of the facility without fifteen (15) days' written notice or up to thirty (30) days as agreed to in the admission agreement to protect the resident or other residents in the facility from harm; and (7-1-99)T
- e. Other written conditions as may be mutually established between the resident, the resident's legal guardian/conservator and the administrator of the facility at the time of admission. (7-1-99)T

03. Admission And Discharge Register. Each facility shall maintain an admission and discharge register listing names of each resident, date admitted, the place from which the resident was admitted, date discharged, reason for discharge, and adequate identification of the facility to which the resident is discharged or future home address. (7-1-99)T

04. Maintaining The Admission And Discharge Register. The admission and discharge register shall be maintained as a separate document, apart from individual resident files, and shall be kept current. (7-1-99)T

424. UNIFORM ASSESSMENT CRITERIA.

01. Facility Responsibility For Private-Pay Residents. The facility shall develop, identify, assess, or direct a uniform needs assessment of private-pay residents who seek supported living services. The Department's uniform assessment tool may be used as the facility's identified uniform needs assessment. (7-1-99)T

02. Information To Be Included In A Uniform Needs Assessment For Private-Pay Residents. The uniform needs assessment instrument used by the facility for private-pay residents shall include, but not be limited to identification/background information, medical diagnosis, medical and health problems, prescription and over the counter medications, behavior patterns, cognitive function, functional status, and assessed level of care. (7-1-99)T

03. Qualifications Of Person Making Uniform Needs Assessments For Private-Pay Residents. The uniform needs assessment shall be conducted by persons who are trained in administering the facility's identified uniform needs assessment instrument. (7-1-99)T

04. Time Frames For Completing The Uniform Needs Assessment Instrument For Private-Pay Residents. The assessment will be completed no later than fourteen (14) calendar days after admission. The assessment shall be reviewed when there is a change in need or every twelve (12) months whichever comes first. (7-1-99)T

05. Use Of Uniform Needs Assessment For Determining The Ability Of Facility To Meet Private-Pay Resident Needs. The results of the assessment may be used to evaluate the ability of an administrator and facility

to meet the identified residents' needs. The results of the assessment may also be used to determine the need for special training or licenses or certificates that may be required in caring for certain residents. (7-1-99)T

06. Use Of The Uniform Needs Assessment Instrument In Determining Facility Staffing Ratios For Private-Pay Residents. A facility shall have sufficient numbers and types of personnel to provide care and supervision to all residents within the facility's care in accordance with each resident's negotiated service agreement based on the uniform needs assessment instrument and in accordance with any other rules governing the facility. (7-1-99)T

07. Uniform Assessments For Department Clients. Department clients shall be assessed by the Department in accordance with IDAPA 16.03.23, "Rules Governing Uniform Assessments for State-Funded Clients". (7-1-99)T

425. NEGOTIATED SERVICE AGREEMENT.

01. Use Of Negotiated Service Agreement. Each resident shall enter into a negotiated service agreement to provide for coordination of services and for guidance of the personnel and management of the facility where the person resides. A personal care services plan of care and an Individual Support Plan which includes the core elements of the Negotiated Service Agreement is considered equivalent to the Negotiated Service Agreement. Upon completion, the agreement shall clearly identify the resident and describe the services to be provided to the resident and how such services are to be delivered, and the Negotiated Service Agreement shall be implemented. (7-1-99)T

02. Core Elements Of The Negotiated Service Agreement, Plan Of Care, Or Individual Support Plan. A resident's service plan shall be based on the following, but not limited to: (7-1-99)T

- a. Assessment; (7-1-99)T
- b. Service needs for activities of daily living; (7-1-99)T
- c. Need for limited nursing services; (7-1-99)T
- d. Need for medication assistance; (7-1-99)T
- e. Frequency of needed services; (7-1-99)T
- f. Level of assistance; (7-1-99)T
- g. Habilitation/Training needs, to specify the program being used; (7-1-99)T
- h. Behavioral management needs, to include a specific plan which identifies situations that trigger inappropriate behavior; (7-1-99)T
- i. Physician's signed and dated orders; (7-1-99)T
- j. Admission records; (7-1-99)T
- k. Community support systems; (7-1-99)T
- l. Resident's desires; (7-1-99)T
- m. Transfer/discharge; and (7-1-99)T
- n. Other identified needs. (7-1-99)T

03. Signature And Approval Of Agreement. The administrator and resident/resident's legal guardian/conservator, shall sign the service agreement upon its completion, no later than fourteen (14) calendar days after the

resident's admission. (7-1-99)T

04. Signing Date That The Agreement Was Approved. The administrator and resident/resident's legal guardian/conservator shall date the service agreement upon its completion, not to exceed fourteen (14) calendar days after the resident's admission. (7-1-99)T

05. Review Date. The service agreement shall document the next scheduled date of review. (7-1-99)T

06. Development Of The Service Agreement. The facility administrator shall consult the resident and those other relevant persons identified by the consumer/resident, in the development of their service agreement. As required by applicable program requirements, licensed and professional staff will be involved in the development of the plan. (7-1-99)T

07. Provision Of Copy Of Agreement. Signed copies of the agreement shall be given to the resident, to the resident's legal guardian/conservator, or for Department clients, to the Department for review, and authorization and approval, and a copy placed in the resident's records file, no later than fourteen (14) calendar days from admission. (7-1-99)T

08. Resident Choice. A resident shall be given the choice and control of how and what services the facility or external vendors will provide, to the extent the resident can make choices. (7-1-99)T

09. Record. A record shall be made of any changes or inability to provide services outlined in the negotiated service agreement. (7-1-99)T

10. External Services. The agreement shall include a statement regarding when there is no need for access to external services. (7-1-99)T

11. Periodic Review. The negotiated service agreement may be reviewed as necessary but must be reviewed at least every six (6) months. (7-1-99)T

426. RESIDENT RECORDS.

01. Admission Records. Records required for admission to a facility shall be maintained and updated and shall be confidential. Their availability without the consent of the resident, subject to IDAPA 16.05.01, "Rules Governing the Protection and Disclosure of Department Records," shall be limited to the facility staff, professional consultants, the resident's physician and representatives of the Department. All entries shall be kept current, recorded legibly in ink, dated, signed, and shall include, but not be limited to, the following: (7-1-99)T

- a. Name and Social Security number; and (7-1-99)T
- b. Permanent address if other than the facility; and (7-1-99)T
- c. Marital status and sex; and (7-1-99)T
- d. Birth place and date of birth; and (7-1-99)T
- e. Name and addresses of responsible agent or agency including telephone numbers; and (7-1-99)T
- f. Personal physician and dentist; and (7-1-99)T
- g. Admission date and name of person who completed admission form; and (7-1-99)T
- h. Results of a history and physical examination performed by a licensed physician or nurse practitioner within six (6) months prior to admission; and (7-1-99)T
- i. For persons not clients of the Department, the history and physical shall include a description of the functional abilities of the resident including his specific strengths and limitations and the specific needs for personal

assistance and supervision indicating that the resident is appropriate for placement in a facility; and (7-1-99)T

j. A list of medications, diet, and treatments prescribed for the resident which is signed and dated by the physician giving the order; and (7-1-99)T

k. Religious affiliation if resident chooses to so state; and (7-1-99)T

l. Interested relatives and friends other than those outlined in Subsection 426.01.e. to include, names, addresses, and telephone numbers of family members, legal guardian/conservator, and significant others; and (7-1-99)T

m. For clients of the Department a psychosocial history, completed within six (6) months prior to admission, by a licensed social worker, psychologist, psychiatrist, or licensed physician; and (7-1-99)T

n. Social information, obtained by the facility through interview with the resident, family, case manager, targeted service coordinator or legal guardian/conservator. The information shall include the resident's social history, hobbies, and interests; and (7-1-99)T

o. Written admission agreement which is signed and dated by the administrator and the resident/resident's legal guardian/conservator; and (7-1-99)T

p. A signed copy of the resident's bill of rights as detailed in Section 250, or documentation that the resident or resident's legal guardian/conservator has read and understands his rights as a resident of the facility; and (7-1-99)T

q. A copy of the resident's admission Uniform Assessment Instrument for residential and assisted living; and (7-1-99)T

r. A copy of the signed and dated admission negotiated service agreement; plan of care, or individual support plan between the resident/resident's legal guardian/conservator and the facility. (7-1-99)T

02. Ongoing Resident Records. At the time of admission, an inventory of items belonging to the resident shall be developed. That inventory can be updated at any time during their stay. Records shall be kept current, to include but not be limited to: (7-1-99)T

a. Admission information as required in Section 426.01 of this Chapter; and (7-1-99)T

b. A current list of medications, diet, and treatments prescribed for the resident which is signed and dated by the physician giving the order. Current orders may be a copy of the signed doctor's order from the pharmacy; and (7-1-99)T

c. Any incident/accident occurring while the resident is in the facility; and (7-1-99)T

d. Documentation of any medication refused by the resident, not given to the resident or not taken by the resident with the reason for the omission. All PRN medication shall be documented with the reason for taking the medication; and (7-1-99)T

e. Notes from the contract nurse, home health, physical therapy, or other service providers, or all documenting the services provided to each resident at each visit; and (7-1-99)T

f. Documentation of significant changes in the residents' physical, mental status, or both and the facility's response; and (7-1-99)T

g. If appropriate, the resident's financial trust fund accounting records; and (7-1-99)T

h. The resident's Uniform Assessment Instruments, to include the admission assessment and all assessments for the past year, for facility care; and (7-1-99)T

- i. Signed and dated negotiated service agreements, plans of care, or individual support plans, to include the admission negotiated service agreement and all service agreements for the past year, between the resident/resident's legal guardian/conservator and the facility; and (7-1-99)T
- j. Contact name, address, phone number of individuals providing paid supports; and (7-1-99)T
- k. Signed copies of all care plans that are prepared by all outside service agencies. (7-1-99)T

03. Maintenance Of Resident Records. Resident records shall be maintained on each resident at the facility for not less than one (1) year after the resident has left the facility. (7-1-99)T

427. RESIDENT CHARGES AND FINANCIAL RECORDS.

01. Resident Funds Policies. If a resident's funds are turned over to the facility or administrator for any purpose other than payment for services allowed under these rules, or if the facility administrator, his relative, or personnel act as resident payee, the facility will be deemed to be handling residents' funds. Each facility shall develop and implement a policy and procedure outlining how residents' funds shall be handled. This policy and procedure shall include, but not be limited to, the following: (7-1-99)T

- a. The facility policy and procedure shall state whether the facility shall or shall not handle residents' funds. (7-1-99)T
- b. This policy or procedure shall be clearly stated in the admission policy and in the admission agreement. (7-1-99)T
- c. If the facility is deemed to manage funds and the resident leaves the facility under any circumstances, the facility can only retain room and board funds prorated to the last day of the fifteen (15) day notice period, or thirty (30) day notice period per agreement, or upon moving from the facility, whichever is later. All remaining funds must follow the resident, and resident funds must be used for resident expenses until a new payee is appointed. (7-1-99)T

02. Handling Of Resident Funds. If the facility agrees to handle residents' funds, the following shall apply: (7-1-99)T

- a. A separate trust account must be established for each resident. There can be no commingling of resident funds with facility funds. Borrowing between resident accounts is prohibited; (7-1-99)T
- b. Each resident shall be notified that a trust fund is available for his use if he needs this service; (7-1-99)T
- c. If it is determined that a resident needs the use of a trust fund service, the facility shall be required to deposit the residents' funds into a trust fund; (7-1-99)T
- d. A provision to bill each resident for his facility care charges on a monthly basis from the trust account; (7-1-99)T
- e. A provision to document on a monthly or on a weekly basis any financial transactions in excess of five dollars (\$5) between the resident and the facility or any of the facility's personnel. A separate transaction record shall be maintained for each resident; (7-1-99)T
- f. In any case in which the facility cannot produce proper accounting records of residents' funds or property, the facility shall be presumed to owe the funds not accounted for to the resident and restitution of the funds to the resident shall be a condition for continued operation of the facility; (7-1-99)T
- g. The facility shall not require the resident to purchase goods or services from the facility for other than those designated in the admission policies, or the admission agreement, or both; (7-1-99)T

h. The facility shall afford the resident or the resident's legal guardian/conservator or person of the resident's choosing access to the resident's financial record; (7-1-99)T

i. The facility shall afford the resident access to the his funds at least between the hours of 7 a.m. to 11 p.m. seven (7) days per week; (7-1-99)T

j. Upon the death of a private-pay resident, with a trust fund, the facility must convey the resident's personal funds and a final accounting of such funds to the individual administering the resident's estate within ninety (90) days; and (7-1-99)T

k. Upon the death of a client of the Department, with a trust fund, the facility must convey the resident's personal funds and a final accounting of such funds to the Department within thirty (30) calendar days. (7-1-99)T

428. MEDICATION STANDARDS AND REQUIREMENTS.

01. Medication Policy. Each facility shall develop and implement a written medication policy and procedure that outlines in detail the procedures to be followed regarding the delegation of medications and to include the requirements of the Administrative Rules of the Board of Nursing, IDAPA 23.01.01, "Rules of the Board of Nursing," Subsection 010.05, Section 400, Subsections 400.02, 400.04, and 400.05 where applicable. The medication policy shall include, but not be limited to, the following: (7-1-99)T

a. If the resident is granted responsibility for his own medication, a written approval stating that the resident is capable of self-administration of medications, must be obtained from the resident's primary physician; (7-1-99)T

b. The facility shall take the necessary precautions to protect residents from obtaining medications that are being stored either in individual resident rooms or by the facility; (7-1-99)T

c. The facility administrator shall be responsible for providing the necessary assistance to the resident in taking his medication; (7-1-99)T

d. Documentation of any medication refused by the resident, not given to the resident or not taken by the resident with the reason for the omission. All PRN medication shall be documented with the reason for taking the medication. (7-1-99)T

02. Medication Distribution System. Medi-sets, blister pack, or other system as approved by the department must be filled by a pharmacist and appropriately labeled in accordance with pharmacy standards. A licensed nurse may fill Medi-sets which must be appropriately labeled with medication name, dosage, amount and time to be taken, and special instructions if appropriate. (7-1-99)T

03. Assistance With Medication. PRN medications and temporary routine medications of fourteen (14) days or less may be maintained in an appropriately labeled multidose container. Each medication must be given to the resident directly from the medi-set or blister pack or medication container. The resident must be observed taking the medication. (7-1-99)T

04. Unused Medication. Unused or discontinued medications shall not accumulate at the facility for longer than thirty (30) days, unless there is reason to believe that the medication will be reordered by the attending physician within a reasonable length of time. The unused medication shall be disposed of in a manner that assures that it cannot be retrieved. A written record of all disposal of drugs shall be maintained in the facility and shall include: (7-1-99)T

a. A description of the drug, including the amount; (7-1-99)T

b. The resident for whom the medication was prescribed; (7-1-99)T

- c. The reason for disposal; (7-1-99)T
- d. The method of disposal; and (7-1-99)T
- e. Signatures of responsible facility personnel and a witness. (7-1-99)T

429. ACTIVITIES.

01. Policy And Plan. Each facility shall assist, encourage and promote residents to maintain and develop their highest potential for independent living through their participation in recreational and other activities. (7-1-99)T

02. Activity Opportunities. The facility shall provide opportunities so the following activities are available to residents: (7-1-99)T

- a. Socialization through group discussion, conversation, recreation, visiting, arts and crafts, music; (7-1-99)T
- b. Daily living activities to foster and maintain independent functioning; (7-1-99)T
- c. Physical activities such as games, sports, and exercises which develop and maintain strength, coordination, and range of motion; (7-1-99)T
- d. Education through special classes or activities; and (7-1-99)T
- e. Leisure time so residents may engage in activities of their own choosing. (7-1-99)T

03. Community Resources For Activities. The facility shall utilize community resources to promote resident participation in integrated activities of their choice both in and away from the facility. (7-1-99)T

430. NURSING SERVICES.

A licensed nurse shall visit the facility at least once every month, not to exceed a forty (40) day time period. Verification of the nurse's current license must be on file at the facility. That nurse shall perform the following functions: (7-1-99)T

01. Resident Response To Medications. Conduct a nursing assessment of each resident's response to medications; and (7-1-99)T

02. Current Medication Orders. Assure that the residents' medication orders are current by verifying that the medication listed by the pharmacist on the medi-set, blister pack, or medication container, to include over-the-counter-medication as appropriate, is current with physician orders; and (7-1-99)T

03. Resident Health Status. Conduct a nursing assessment, in accordance with the resident's uniform assessment and negotiated service agreement, of the health status of each resident by identifying symptoms of illness, or changes, or both in mental and physical health status; and (7-1-99)T

04. Recommendations. Make recommendations to the administrator regarding any medication needs or other health need requiring follow up; and (7-1-99)T

05. Progress Of Previous Recommendations. Conduct a nursing assessment of the progress on previous recommendations made to the administrator regarding any medication needs or other health needs that required follow up; and (7-1-99)T

06. Self Medicator. Conduct a nursing assessment on each resident participating in a self administration medication regime of the resident's ability to safely continue the self administration medication regime for the next month; and (7-1-99)T

07. Medication Interactions And Usage. Conduct a review of residents' use of over-the-counter medications for side effects, interactions, abuse or a combination of these adverse effects. If side effects are determined the nurse shall notify the resident's physician and make the appropriate counseling available to the resident; and (7-1-99)T

08. Date. Document the nursing assessments with the date of each visit. (7-1-99)T

431. -- 449. (RESERVED).

450. FOOD SERVICE.

01. Food Services Provided By Facility. When food services are provided by any facility, the following standards and requirements shall be met: (7-1-99)T

a. Assure that all persons wear clean garments and an apron, smock, or other cover-up when working in the kitchen. Long, shoulder length, hair shall be restrained; (7-1-99)T

b. Assure that all persons keep their hands clean at all times while engaged in preparing and serving food and drink. Hands shall be rewashed each time the person returns to the kitchen from other activities in the facility; and (7-1-99)T

c. Assure that no person having a communicable disease in the transmittable stage or who is suspected of being a carrier of organisms that may cause a communicable disease shall not be involved in food preparation and service. (7-1-99)T

02. Policies Of Nutritional Care. Facilities with a licensed bed capacity of sixteen (16) or more residents shall have written policies and procedures for providing proper nutritional care of its residents whether provided by the facility or a third party. Policies shall include at least the following: (7-1-99)T

a. Job descriptions; (7-1-99)T

b. Personnel responsibilities; (7-1-99)T

c. Procedures to follow if a resident refuses food; and (7-1-99)T

d. Food handling and sanitation procedures. (7-1-99)T

451. MENU PLANNING.

Residents' shall be provided at least the minimum food and nutritional needs of the residents in accordance with the current Recommended Dietary Allowances established by the Food and Nutrition Board of the National Research Council, adjusted for age, sex and activity. (7-1-99)T

01. Additional Menu Items. Items on the menu shall: (7-1-99)T

a. Include foods commonly served within the community and to which the residents are accustomed; (7-1-99)T

b. Reflect seasonal food selections as well as residents' food habits, preferences, and physical abilities; (7-1-99)T

c. Provide a sufficient variety of foods in adequate amounts at each meal; (7-1-99)T

d. Be varied for each day of the week, different for the same days from week to week; and (7-1-99)T

e. Not include restrictions of any kind based on dietary beliefs or practices of the owner and administrator unless the facility's admission policies clearly indicate. (7-1-99)T

- 02. Menus Must:** (7-1-99)T
- a. Be reviewed, signed and dated by a dietitian, nutritionist or home economist ensuring that the menus meet the current RDAs before being implemented; (7-1-99)T
 - b. Be available where they can be easily viewed by residents upon request; (7-1-99)T
 - c. Be corrected to reflect substitutions that were made and snacks provided; and (7-1-99)T
 - d. Be kept on file in the facility for three (3) months. (7-1-99)T
 - e. Facilities of sixteen (16) residents or more shall have available in the kitchen a current diet manual approved by the licensing agency. A facility using a diet manual other than the Idaho Diet Manual shall be submitted to the licensing agency for approval.

03. Facilities With Fifteen Beds Or Less. In facilities of fifteen (15) beds or less, menus shall be planned, in writing at least three (3) weeks in advance for regular diets. (7-1-99)T

04. More Than Sixteen Beds. Facilities serving sixteen (16) or more residents shall develop and implement a cycle menu which covers a minimum of two (2) seasons and is six (6) to nine (9) weeks in length. (7-1-99)T

452. MODIFIED OR THERAPEUTIC DIETS.

Modified or Therapeutic Diets. When therapeutic diet services are provided, the facility shall meet the following. (7-1-99)T

- 01. Modified Or Therapeutic Diet.** Have on file, a physician's order for each modified or therapeutic diet; (7-1-99)T
- 02. Planned Or Approved Menu.** Have a menu planned or approved, signed and dated by a dietitian prior to being served, which meets the nutritional standards to the extent possible; (7-1-99)T
- 03. Regular Diet Menu.** The menu shall be planned as close to the regular diet as possible; (7-1-99)T
- 04. Types And Amounts Of Food To Be Served.** Have readily available, in the kitchen, the meal pattern, including types and amounts of food to be served; (7-1-99)T
- 05. Serve The Menu As Planned;** and (7-1-99)T
- 06. Keep The Therapeutic Menus On File For Three Months.** (7-1-99)T

453. FOOD STORAGE.

01. Food Storage Temperature. All potentially hazardous foods and beverages shall be kept at a safe temperature, forty-five (45) degrees Fahrenheit or below and at one hundred forty (140) degrees Fahrenheit or above, except during necessary periods of preparation and service. (7-1-99)T

02. Frozen Food Storage Temperatures. Frozen foods shall be maintained at zero (0) degrees or below except during necessary periods of preparation and service. (7-1-99)T

03. Refrigerator And Freezer Temperature. Each refrigerator and freezer used for storage of perishable food shall be provided with an accurate thermometer located in the warmest part toward the side front of the refrigerator and where the temperature can be easily and readily observed. (7-1-99)T

04. Thawing Of Frozen Food. Frozen foods which are potentially hazardous if not properly handled shall be thawed for preparation in one (1) of the following ways: (7-1-99)T

- a. In refrigerated units at a temperature not exceeding forty-five (45) degrees Fahrenheit; (7-1-99)T
 - b. Under potable running water, at a temperature of seventy (70) degrees Fahrenheit or below, with sufficient water velocity to agitate and float off loose particles into the overflow; (7-1-99)T
 - c. In a microwave oven; or (7-1-99)T
 - d. As part of a conventional cooking process. (7-1-99)T
- 05. Safe Food.** Food received or used in facility shall be clean, wholesome, free from spoilage, adulteration, misbranding, and safe for human consumption. Outdated products shall not be used. (7-1-99)T
- 06. Food Storage.** Stored food shall be placed in such a manner as to be kept from dust and splash contamination. All food shall be stored off the floor. (7-1-99)T
- 07. Canned Food.** Food contained in rusted, dented, or unlabeled cans shall not be used. (7-1-99)T
- 08. Food Supply.** The facility shall maintain a seven (7) day supply of nonperishable foods and a two (2) day supply of perishable foods. (7-1-99)T

454. FOOD PREPARATION AND SERVICE.

- 01. Food Preparation.** Foods shall be prepared by methods that conserve nutritional value, flavor, and appearance. (7-1-99)T
- 02. Raw Unprocessed Food.** Raw unprocessed food, fruits, or vegetables shall be thoroughly washed before use. (7-1-99)T
- 03. Home Canned Foods.** Home canned foods shall not be served except home canned jams, jellies, fruits, pickles, and preserves. (7-1-99)T
- 04. Dry Milk Products.** Reconstituted dry milk and dry milk products; i.e., whey, may be used only in instant desserts, whipped products, or for cooking and baking purposes. (7-1-99)T
- 05. Meal Spacing.** Not more than fourteen (14) hours shall elapse between the end of an evening meal and the beginning of the following morning meal containing a protein food. (7-1-99)T
- 06. Meal Intervals.** Intervals between breakfast and lunch and lunch and dinner shall not be less than four (4) hours nor more than six (6) hours between each. (7-1-99)T
- 07. Main Meal.** If the main meal of the day is served at noon, the evening meal shall include at least one (1) ounce of a protein food (meat, cheese, fish, or egg), vegetable, fruit or dessert, and beverage preferably milk. (7-1-99)T
- 08. Temperature Of Served Food.** Foods shall be attractively served at proper temperatures. (7-1-99)T
- 09. Form Of Food Served.** Foods shall be served in a form to meet individual resident's needs. (7-1-99)T
- 10. Boxed Lunch And Dinner Meal.** If residents carry lunches, box or sack, at noon, the main meal shall be served in the evening. (7-1-99)T
- 11. Box Lunch Nutrition.** A box lunch shall be nutritionally adequate and varied. (7-1-99)T

12. Standardized Recipes. For facilities serving sixteen (16) or more individuals, standardized recipes shall be required. (7-1-99)T

455. FOOD SERVICE SANITATION STANDARDS.

01. Pots And Pans. Pots and pans shall be adequate in number and shall be maintained in a smooth, nonpitted, easily cleanable condition. (7-1-99)T

02. Cups, Dishes, and Utensils. Cups, dishes, and eating utensils that are stained, pitted, chipped, unglazed, or not easily cleanable shall not be used. (7-1-99)T

03. Food Service Walls. The walls of all food preparation, utensil washing, and hand washing rooms or areas shall have smooth, easily cleanable surfaces and shall be washable up to the highest level by splash or spray. (7-1-99)T

04. Water. Hot and cold running water under pressure shall be easily accessible to all rooms where food is prepared or utensils are washed. (7-1-99)T

05. Live Animals. No live animals or fowl shall be kept or maintained in the food service area. (7-1-99)T

06. Living Quarters. Neither food preparation, nor service areas, shall be used as living quarters for facility personnel. (7-1-99)T

07. Garbage, Trash, And Rubbish. All garbage, trash, and rubbish shall be collected and disposed of in a sanitary manner. (7-1-99)T

a. All garbage, trash, and rubbish shall be collected daily and taken to storage facilities; (7-1-99)T

b. Garbage shall be removed from storage facilities frequently enough to prevent a potential health hazard; (7-1-99)T

c. Wet garbage shall be collected and stored in impermeable, leak proof, fly tight containers pending disposal; and (7-1-99)T

d. All containers, storage areas, and surrounding premises shall be kept clean and free of vermin. (7-1-99)T

08. UNICODE. The acquisition, preparation, including freezing, canning, storage and serving of all food and drink and the washing of dishes in a facility shall comply with IDAPA 16.02.19, "Rules Governing Food Safety and Sanitation Standards for Food Establishments (UNICODE)," February 1, 1998, which is incorporated herein by reference and outlined in Section 008. (7-1-99)T

456. -- 474. (RESERVED).

475. ENVIRONMENTAL SANITATION STANDARDS.

01. Responsibility For Maintenance Of Sanitary Conditions. The facility is responsible for the prevention of disease and for the maintenance of sanitary conditions. (7-1-99)T

02. Water Supply. The water supply for the facility shall be adequate, of a safe, and sanitary quality, to include, but not be limited to: (7-1-99)T

a. A Department approved private, public, or municipal water supply shall be used; (7-1-99)T

b. If water is from a private supply, water samples shall be submitted to the Department through a

private accredited laboratory or the District Public Health Laboratory for bacteriological examination at least annually or more frequently if deemed necessary by the Department. Copies of the laboratory reports shall be kept on file at the facility; and (7-1-99)T

c. There shall be a sufficient amount of water under adequate pressure to meet the sanitary requirements of the facility at all times. (7-1-99)T

03. Sewage Disposal. All sewage and liquid wastes shall be discharged, collected, treated, and disposed of in a manner approved by the Department. (7-1-99)T

04. Garbage And Refuse Disposal. Garbage and refuse disposal shall be provided by the facility. The disposal method, shall include, but not be limited to: (7-1-99)T

a. Garbage containers both inside and outside the facility, used for storage of garbage and refuse, shall be constructed of durable, non-absorbent materials and shall not leak; (7-1-99)T

b. Garbage containers in common areas both inside and outside the facility, used for storage of garbage and refuse, shall be provided with tight-fitting lids; (7-1-99)T

c. Garbage containers shall be maintained in good repair; (7-1-99)T

d. Sufficient garbage containers shall be afforded to hold all garbage and refuse which accumulates between periods of removal from the premises of the facility; and (7-1-99)T

e. Storage areas shall be kept clean and sanitary. (7-1-99)T

f. If public or contract garbage collection service is available, the facility shall subscribe to these services. (7-1-99)T

05. Insect And Rodent Control. The facility shall be maintained free from infestations of insects, rodents, and other pests. Toxic chemicals and pesticides used in the control program shall be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer. Toxic chemicals and pesticides shall be: (7-1-99)T

a. Properly labeled; and (7-1-99)T

b. Stored in an area separate from where food is stored, prepared, and served or where medications are stored; and, (7-1-99)T

c. Not stored in resident areas. (7-1-99)T

06. Linen-Laundry Facilities And Services. Adequate facilities and procedures shall be provided for the proper and sanitary washing of linen and other washable goods laundered at the facility. The linen-laundry facility shall: (7-1-99)T

a. Have available at all times a quantity of linen essential to the proper care and comfort of residents. Two (2) complete changes of clean bed linen shall be on hand for each licensed bed in the facility. The use of torn or unclean bed linen is prohibited; (7-1-99)T

b. Be well-lighted and have ventilation adequate in size for the needs of the facility, maintained in a sanitary manner, and kept in good repair; and (7-1-99)T

c. If linen and personal laundry are sent out, care shall be taken that soiled linen and clothing are properly handled before sending out, and that clean linen and clothing are received and stored in the proper manner. (7-1-99)T

07. Soiled Linen Handling. Soiled linen shall be handled as follows: (7-1-99)T

- a. All soiled linen shall be collected, stored, and transported in a sanitary manner; (7-1-99)T
- b. Soiled linen shall not be sorted, processed, or stored in kitchens, food preparation areas, or food storage areas; and (7-1-99)T
- c. Soiled linen shall not be allowed to accumulate at the facility. (7-1-99)T
- 08. Clean Linen Handling.** Clean linen shall be handled as follows: (7-1-99)T
 - a. Clean linen shall be handled, stored, dried, and sorted in a sanitary manner; (7-1-99)T
 - b. Closets for the storage of clean linen shall be provided on each floor and in each building where residents sleep; and (7-1-99)T
 - c. Residents' and personnel laundry shall be collected, transported, sorted, washed, and dried in a sanitary manner and shall not be washed with bed linens. (7-1-99)T
- 09. Labeled Clothing.** Residents' clothing laundered by the facility shall be labeled to ensure proper return to the owner only if likely to be commingled. (7-1-99)T
- 10. Housekeeping Services And Equipment.** Sufficient housekeeping, maintenance personnel, and equipment shall be provided to maintain the interior and exterior of the facility in a clean, safe, and orderly manner. Prior to occupancy of any sleeping room by a new resident, the room shall be thoroughly cleaned including the bed, bedding, and furnishings. (7-1-99)T

476. -- 499. (RESERVED).

500. REQUIREMENTS FOR FIRE AND LIFE SAFETY STANDARDS.

- 01. Local And State Codes.** Buildings on the premises used as a facility must meet all requirements of local and state codes concerning fire and life safety that are applicable to licensed residential and assisted living facilities. (7-1-99)T
- 02. Life Safety Code Requirements.** Licensed residential and assisted living facilities shall meet the provisions of the Life Safety Code of the National Fire Protection Association, 1988 Edition, which are applicable to residential and assisted living facilities as specified below and outlined in Section 008. (7-1-99)T
- 03. Existing Facilities Housing Nine Or Less Residents.** Existing facilities licensed prior to July 1, 1992, and housing nine (9) or less residents on the first story only shall comply with the requirements of Chapter 21, Residential Board and Care Section of the Life Safety Code, 1988 Edition for Prompt Evacuation Capability except that the requirement for door closures on sleeping room doors shall not apply. Facilities may elect to comply with the fire safety evaluation system for Residential Board and Care, Prompt Evacuation Capability as outlined in Chapter 6 of NFPA Manual 101M, 1988 Edition which is incorporated by reference and outlined in Section 008. (7-1-99)T
- 04. New Buildings.** Newly constructed buildings or buildings being converted to a facility, or both, after July 1, 1992, and who house nine (9) or less residents on the first story only shall comply with the requirements of Chapter 21, Residential Board and Care Section of the Life Safety Code, 1988 Edition for Impractical Evacuation Capability. Exceptions: (7-1-99)T
 - a. Any newly constructed building or building being converted to a facility and who house only residents classified as Level I or Level II need only comply with the requirements for Prompt Evacuation Capability as outlined in Subsection 500.03; (7-1-99)T
 - b. In any newly constructed building or building being converted to a facility, the minimum water supply for residential sprinkler systems shall be equal to the water demand rate times ten (10) minutes; and (7-1-99)T

c. A facility may elect to comply with the Fire Safety Evaluation System (FSES) for Residential Board and Care, Impractical Evacuation Capability, as outlined in Chapter 6 of NFPA Manual 101M, 1988 Edition which is incorporated by reference and outlined in Section 008. (7-1-99)T

05. Facilities Housing Ten Through Fifteen Residents. Buildings housing ten (10) through fifteen (15) residents on the first story only shall comply with the requirements of either: (7-1-99)T

a. The Limited Care Section of the Life Safety Code, 1988 Edition; (7-1-99)T

b. Chapter 21, Residential Board and Care Section of the Life Safety Code, 1988 Edition, for Impractical Evacuation Capability and have a Department approved resident safety plan which includes staffing. A facility may elect to comply with the Fire Safety Evaluation System (FSES) for Residential Board and Care, Impractical Evacuation Capability, as outlined in Chapter 6 of NFPA Manual 101M, 1988 Edition which is incorporated by reference and outlined in Section 008; or (7-1-99)T

c. The minimum water supply for the residential sprinkler system shall be equal to the water demand rate times ten (10) minutes. (7-1-99)T

06. Housing Of Sixteen Or More Residents. Buildings housing sixteen (16) or more residents or any building housing residents on stories other than the first story shall comply with the Limited Care Section of the Life Safety Code, 1988 Edition. Exception: Facilities licensed prior to July 1, 1992, may continue to comply with the Residential Custodial Care Section of the Life Safety Code, 1981 Edition as outlined in Section 008. Existing licensed facilities shall be in compliance by July 1, 1994. (7-1-99)T

07. Fire Alarm/Smoke Detection System. An electrically supervised, manually operated fire alarm/smoke detection system shall be installed throughout each building housing residents. The system shall include a control panel, manual pull stations, smoke detectors, sounding devices, power backup and any sprinkler flow/alarm devices that may be present and must be compatible with any future sprinkler system add on. The system, including devices, their location, and installation shall be approved by the licensing agency prior to installation. Buildings licensed prior to July 1, 1992, shall be given until July 1, 1995, to install the system. Exception: Facilities that comply with the requirements of Chapter 21, Residential Board and Care Section of the Life Safety Code, 1988 Edition for Impractical Evacuation Capability. (7-1-99)T

08. Corridors Or Hallways. Dead-end corridors or dead-end hallways shall not exceed thirty (30) feet in length. (7-1-99)T

09. Resident Placement. Any resident requiring assistance in ambulation shall reside on the first story unless the facility complies with Subsection 500.06. (7-1-99)T

10. Fire Drills. All personnel and residents shall participate in a minimum of one (1) fire drill per shift per quarter. Fire drills shall be unannounced. Written documentation of each drill shall be maintained on file at the facility and shall contain a description of each drill, the date and time of the drill, response of the personnel and residents, problems encountered and recommendations for improvement, and the name of each personnel in attendance during the drill. (7-1-99)T

11. Structure, Maintenance, Equipment To Assure Safety. The facility shall be structurally sound and shall be maintained and equipped to assure the safety of residents, personnel, and the public, to include, but not be limited to: (7-1-99)T

a. Furnishings, decorations, or other objects shall not be placed so as to obstruct exit access or exits; (7-1-99)T

b. All ramps, open porches, sidewalks, and open stairs shall be maintained free of snow and ice buildup; (7-1-99)T

c. Wood stoves shall be provided with railings or other protection designed to prevent residents from coming into contact with the stove surfaces; (7-1-99)T

- d. All fireplaces shall be provided with heat tempered glass fireplace enclosures or equivalent; (7-1-99)T
- e. Boilers, hot water heaters, and unfired pressure vessels shall be equipped with automatic pressure relief valves; (7-1-99)T
- f. Portable comfort heating devices of any kind shall be prohibited; and
- g. Quantities of flammable and highly combustible materials deemed hazardous by the licensing agency shall not be stored in the facility unless the building is protected throughout by an approved automatic fire extinguishing system. (7-1-99)T
- 12. Natural Or Man-Made Hazards.** On the premises of each facility where natural or man-made hazards are present, suitable fences, guards, railing, or a combination shall be provided to protect the residents. (7-1-99)T
- 13. Weeds, Trash, And Rubbish.** The premises and all buildings used as a facility shall be maintained free from the accumulation of weeds, trash, and rubbish. (7-1-99)T
- 14. Exit Door Locks.** Any locks on exit doors shall be single action easily operable from the inside without the use of keys or any special knowledge. Exception: Special locking arrangements as permitted under Section 5-2.1.6. of the Life Safety Code, 1988 Edition which is incorporated by reference as outlined in Section 008. (7-1-99)T
- 15. Portable Fire Extinguishers.** Portable fire extinguishers shall be installed throughout each building utilized as a facility. Each extinguisher shall be installed in accordance with requirements set forth in NFPA Standard #10, Standard for Portable Fire Extinguishers, 1988 Edition which is incorporated by reference as outlined in Section 008. (7-1-99)T
- 16. Electrical Installations And Equipment.** Electrical installations and equipment shall comply with applicable local or state electrical requirements to include but not be limited to the following: (7-1-99)T
- a. Equipment designed to be grounded shall be maintained in a grounded condition; and (7-1-99)T
- b. Extension cords and multiple electrical adapters shall be prohibited. Exception: Listed grounded multiple electrical adapters with built-in breaker. (7-1-99)T
- 17. Solid Fuel Heating Devices.** Solid fuel heating devices shall be installed in accordance with NFPA Standards #211, Standards for Chimneys, Fireplaces, Vents, and Solid Burning Appliances, 1988 Edition which is incorporated by reference and is outlined in Section 008. (7-1-99)T
- 18. Medical Gases.** Medical gas storage, handling, and use shall be in accordance with NFPA Standard 99, Standards for Health Care Facilities, 1990 Edition which is incorporated by reference and is outlined in Section 008. (7-1-99)T
- 19. Telephone.** There shall be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers shall be posted near the telephone. (7-1-99)T
- 20. Smoking.** The facility shall develop written rules governing smoking; and, these rules shall be adopted, posted, and made known to all facility personnel, residents, and the public. These rules shall include at least the following: (7-1-99)T
- a. Prohibiting smoking in any area where flammable liquids, gases, or oxidizers are in use or stored; (7-1-99)T
- b. Prohibiting residents from smoking in bed; (7-1-99)T

- c. Prohibiting unsupervised smoking by residents classified as not mentally or physically responsible. This includes residents so affected by medication; (7-1-99)T
- d. Prohibiting smoking in areas where combustible supplies or materials are stored; (7-1-99)T
- e. Designating areas for personnel, resident, and public smoking; and (7-1-99)T
- f. Nothing in this section requires that smoking be permitted in a facility whose admission policies prohibit smoking. (7-1-99)T

21. Disaster Preparedness. Each facility shall develop and implement a disaster preparedness plan to follow in the event of fire, explosion, flood, earthquake, high wind, or other disaster. The plan shall include, but not be limited to, the following: (7-1-99)T

- a. Written procedures outlining steps to be taken in the event of a fire including who is to respond, each person's responsibilities, to where residents are to be evacuated, and notification of the fire department; (7-1-99)T
- b. Information as to where residents shall be taken in the event the building cannot be immediately reentered. A written agreement shall be developed between the facility and the location to which residents are to be relocated; and (7-1-99)T
- c. Documentation shall be available in each facility indicating that the residents have been advised, upon admission, of actions required under emergency conditions. (7-1-99)T

22. Report Of Fire. A separate report on each fire incident occurring within the facility shall be submitted to the Department within thirty (30) days of the occurrence. The reporting form, "Facility Fire Incident Report," shall be issued by the Department to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries, if any. (7-1-99)T

501. MAINTENANCE OF EQUIPMENT AND SYSTEMS FOR FIRE AND LIFE SAFETY.

01. Maintenance Of Equipment And Systems. The facility shall assure that all equipment and systems are properly maintained to assure the safety of the residents. (7-1-99)T

02. Fuel-Fired Heating. Fuel-fired heating devices and systems, including wood stoves, shall be inspected/serviced/cleaned at least annually by a person professionally engaged in the business of servicing these devices or systems. The inspection record shall be maintained on file in the facility. (7-1-99)T

03. Portable Fire Extinguishers. Portable fire extinguishers shall be serviced in accordance with NFPA Standard 10, Standard for Portable Fire Extinguishers, 1988 Edition. In addition, portable fire extinguishers shall be examined at least monthly by a designated person in the facility to determine that: (7-1-99)T

- a. Each extinguisher is in its designated location; (7-1-99)T
- b. Each extinguisher seal or tamper indicator is not broken; (7-1-99)T
- c. Each extinguisher has not been physically damaged; (7-1-99)T
- d. Each extinguisher gauge, if provided, shows a charged condition; and (7-1-99)T
- e. The inspection tag attached to the extinguisher shall show at least the initials of the person making the monthly examination and the date of the examination. (7-1-99)T

04. Fire Alarm/Smoke Detection System Service/Testing. (7-1-99)T

a. The facility's fire alarm/smoke detection system shall be inspected/tested/serviced at least annually by a person or business professionally engaged in the servicing of such systems. Results of the inspection/test shall be maintained on file; and (7-1-99)T

b. The fire alarm/smoke detection system shall be inspected/tested at least monthly by a designated facility employee. Results of the inspection/test shall be maintained on file. (7-1-99)T

05. Automatic Fire Extinguishing System - Inspection. All automatic fire extinguishing systems shall be inspected/tested/serviced at least annually by an appropriate contractor licensed by the Idaho State Fire Marshal's office. A report, prepared by the contractor shall be maintained on file in the facility documenting the results of the annual inspection/testing/service. (7-1-99)T

502. -- 524. (RESERVED).

525. BUILDING CONSTRUCTION AND PHYSICAL STANDARDS.

01. Building Character. All buildings utilized as licensed residential and assisted living facilities shall be of such character as to be suitable for such use. Facilities shall be of such character as to enhance normalization and integration of residents into the community. (7-1-99)T

02. Remodeling Or Additions. Remodeling or additions to facilities shall be consistent with and not detract from the residential use of the property. Remodeling which identifies the facility such as remodeling garages when this is not the general practice in the neighborhood or constructing large buildings which overwhelm the lot on which the facility is located is prohibited. (7-1-99)T

03. Approval. All buildings shall be subject to the approval of the licensing agency. (7-1-99)T

04. Walls And Floor Surfaces. Walls and floors shall be of such character to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms shall have smooth enameled or equally washable surfaces. (7-1-99)T

05. Toilet And Bathrooms. Each facility shall provide: (7-1-99)T

a. A toilet and bathroom for resident use so arranged that it is not necessary for an individual to pass through another resident's room to reach the toilet or bath; (7-1-99)T

b. Toilet and bathrooms separated from all adjoining rooms by solid walls or partitions; (7-1-99)T

c. Mechanical ventilation to the outside from all inside toilet and bathrooms without operable windows; (7-1-99)T

d. Each tub, shower, and lavatory connected to hot and cold running water; (7-1-99)T

e. At least one (1) flush toilet for every six (6) persons, residents, or personnel; (7-1-99)T

f. At least one (1) tub or shower for every eight (8) persons, residents, or personnel; (7-1-99)T

g. At least one (1) lavatory with a mirror for each toilet; and (7-1-99)T

h. At least one (1) toilet, tub or shower, and lavatory in each building in which residents sleep, with additional units if required by the number of persons. Residents shall not be required to go outside to get to the toilet, tub or shower, or lavatory. (7-1-99)T

06. Accessibility For Persons With Mobility And Sensory Impairments. For residents with mobility or sensory impairments, the facility shall provide a physical environment which meets the needs of the person for independent mobility and use of appliances, bathroom facilities, and living areas. New construction must meet the requirements of the Americans with Disabilities Act Accessibility Guidelines (ADAAG). Existing facilities shall

comply, to the maximum extent feasible with Title III-4.4000 of the Americans with Disabilities Act, without creating an undue hardship or burden on the facility, and shall provide as required, the necessary accommodations: (7-1-99)T

a. Ramps for residents who require assistance with ambulation shall comply with the requirements of the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.8; (7-1-99)T

b. Bathrooms and doors large enough to allow the easy passage of a wheelchair as provided for in the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.13; (7-1-99)T

c. Grab bars in resident toilet and bathrooms that comply with the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.26; (7-1-99)T

d. Toilet facilities that comply with the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.16 and 4.23; (7-1-99)T

e. Non retractable faucet handles that comply with the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.19 (with the exception of self-closing valves under 4.19.5) and 4.27; and (7-1-99)T

f. Suitable hand railing shall be provided on both sides of all stairs leading into and out of a building for residents who require the use of crutches, walkers, or braces. (7-1-99)T

07. Lighting. The facility shall provide adequate lighting in all resident sleeping rooms, dining rooms, living rooms, recreation rooms, and hallways. (7-1-99)T

08. Ventilation. The facility shall be ventilated, and precautions shall be taken to prevent offensive odors. (7-1-99)T

09. Plumbing. All plumbing in the facility shall comply with local and state codes. All plumbing fixtures shall be easily cleanable and maintained in good repair. (7-1-99)T

10. Heating. A heating system shall be provided for the facility that is capable of maintaining a minimum temperature of seventy (70) degrees Fahrenheit during the day and a minimum of sixty-two (62) degrees Fahrenheit during the night. Wood stoves shall not be permitted as the sole source of heat and the thermostat for the primary source of heat shall be remotely located away from any wood stove. (7-1-99)T

11. Dining/Recreation/Living Space. For facilities licensed after July 1, 1991, the total area set aside for these purposes shall be not less than thirty (30) square feet per resident. A hall or entry shall not be included as living or recreation space. (7-1-99)T

12. Residents Required To Go Outside. Residents requiring the use of wheelchairs, walkers, or assistance with ambulation shall not be admitted to facilities that require residents to go outside to go back and forth from the dining room/shower/bath/recreation areas.

13. Covered Cement Walks. For facilities licensed after July 1, 1991, where residents are required to leave their rooms to go to dining or recreation, covered cement walks are required. (7-1-99)T

14. Resident Sleeping Rooms. The facility shall assure that: (7-1-99)T

a. Each resident sleeping room is not in attics, stairs, halls, or any other room commonly used for other than bedroom purposes; (7-1-99)T

b. A room with a window that opens into an exterior window well shall not be used for a resident sleeping room; (7-1-99)T

c. Not more than four (4) residents shall be housed in any multi-bed sleeping room in facilities licensed prior to July 1, 1991. New facilities or conversions licensed after July 1, 1992, shall not have more than two (2) residents in any multi-bed sleeping room. The sale of a facility licensed prior to July 1, 1992, shall not be

considered a new facility or conversion; (7-1-99)T

d. Square footage requirements for existing facilities that have been continuously licensed since before May 9, 1977, shall provide sleeping rooms which allow for not less than seventy-five (75) square feet of floor space per resident in a single-bed sleeping room and not less than sixty (60) square feet of floor space per resident in a multi-bed sleeping room with a minimum of three (3) feet between beds; (7-1-99)T

e. Square footage requirements for facilities licensed on or after May 9, 1977, shall provide sleeping rooms which allow for not less than one-hundred (100) square feet of floor space per resident in a single-bed sleeping room and not less than eighty (80) square feet of floor space per resident in a multi-bed sleeping room; (7-1-99)T

f. Each resident's sleeping room shall be provided with an operable window. The window opening shall be not less than twenty-two (22) inches wide, twenty-four (24) inches in height, and five and seven-tenths (5.7) square feet in area. Exception: This is not necessary if there is a door to the outside; (7-1-99)T

g. The operable window sill height shall not exceed thirty-six (36) inches above the floor in new construction, additions, or remodeling; (7-1-99)T

h. The operable window sill height shall not exceed forty-four (44) inches above the floor in existing buildings being converted to a facility; (7-1-99)T

i. Each resident sleeping room shall provide a total window space that equals at least ten percent (10%) of the room's total square footage; (7-1-99)T

j. Window screens shall be provided on operable windows; (7-1-99)T

k. Resident sleeping rooms shall be provided with walls that run from floor to ceiling and with doors that will stop the passage of smoke and provide the resident with adequate privacy; (7-1-99)T

l. Ceiling heights in sleeping rooms shall be at least seven (7) feet, six (6) inches; and (7-1-99)T

m. Closet space in each resident sleeping room shall be provided at the rate of at least four (4) square feet per resident. Common closets utilized by two (2) or more residents shall be provided with substantial dividers for separation of each resident's clothing. All closets shall be equipped with doors. Free-standing closets shall be deducted from the square footage of the sleeping room. (7-1-99)T

15. Storage Areas. In addition to the storage area in the resident's room, general storage shall be provided at the rate of ten (10) square feet per licensed bed. (7-1-99)T

16. Intercom System. An intercom system shall be installed in the facility based upon the design of the building, needs of the residents, or staffing pattern. The intercom shall not be a substitute for supervision. (7-1-99)T

17. Dietary Standards. The facility shall assure that: (7-1-99)T

a. Newly constructed facilities, admitting or planning to admit sixteen (16) or more residents, shall submit professionally prepared drawings or plans of the kitchen for review prior to construction; and (7-1-99)T

b. Carpeting is prohibited in the food preparation area, and where existing, shall be replaced with an easily cleanable surface when worn out or becomes heavily soiled. (7-1-99)T

526. REQUIREMENTS FOR EXISTING BUILDINGS TO BE CONVERTED TO A FACILITY.

In addition to requirements set forth in Section 525, buildings to be converted to facilities shall comply with the following: (7-1-99)T

01. Site. The building/home location shall be: (7-1-99)T

a. In a lawfully constituted fire district; and (7-1-99)T

- b. Served by an all-weather road kept open to motor vehicles at all times of the year; and (7-1-99)T
- c. Accessible to physician or emergency medical services within thirty (30) minutes driving time; and (7-1-99)T
- d. Accessible within thirty (30) minutes driving time to necessary social, medical, and rehabilitation services. (7-1-99)T

02. Occupancy Approval. Any building proposed for conversion to a facility shall be approved by the licensing agency prior to issuance of a license. Any items of noncompliance shall be corrected prior to issuance of the license. (7-1-99)T

03. Use Of Modular (i.e., Factory Built) Buildings And Manufactured Homes. Modular Buildings as defined in Section 39-4105, Idaho Code, must conform to the requirements of the Uniform Building Code unless approved for use as a facility prior to July 1, 1999, and may continue to be licensed when evaluated on a case-by-case basis for fire and life safety issues. Manufactured Homes as defined in Section 39-4105, Idaho Code, shall not be used. (7-1-99)T

527. NEW CONSTRUCTION, ADDITIONS, ALTERATIONS.

01. Construction. Facilities whose construction commenced after July 1, 1991, or buildings being converted to a facility after July 1, 1991, shall conform to the requirements of the Life Safety Code, 1988 Edition, Chapter 12, for a Limited Care Facility. Exception: A building housing fifteen (15) beds or less where all sleeping rooms are located on the first story, may comply with the requirements of the Life Safety Code, 1988 Edition, Chapter 21, Residential Board and Care which is incorporated by reference and is outlined in Section 008. See Section 500. (7-1-99)T

02. Plans And Specifications. Plans and specifications on any new facility or any addition/remodeling are governed by the following: (7-1-99)T

- a. Plans shall be prepared by an architect or engineer licensed in the state of Idaho. A variance of this requirement may be granted by the licensing agency when the size of the project does not necessitate involvement of an architect or engineer; (7-1-99)T
- b. Prior to commencing work, plans and specifications shall be submitted to, and approved by, the licensing agency to assure compliance with applicable construction standards, codes, and regulations; (7-1-99)T
- c. Preliminary plans, to be submitted, shall include the assignment of all spaces, size of areas and rooms; (7-1-99)T
- d. Preliminary plans, to be submitted, shall include drawings of each floor including, but not limited to, the basement, approach or site plan, roads, parking areas, and sidewalks; (7-1-99)T
- e. Preliminary plans, to be submitted, shall include outline specifications describing the general construction, including interior finishes, acoustical material, heating, electrical, and ventilation systems; (7-1-99)T
- f. Preliminary plans, to be submitted, shall be drawn to scale of sufficient size to clearly present the proposed design, but not less than a scale of one-eighth (1/8) inch to the foot; (7-1-99)T
- g. Working drawings shall be developed in close cooperation and with approval of the licensing agency and other appropriate agencies prior to construction; (7-1-99)T
- h. Working drawings shall be of accurate dimensions and shall include all necessary explanatory notes, schedules, and legends. The drawings shall be stamped/signed by the architect or engineer; and (7-1-99)T

- i. Working drawings shall be complete and adequate for contract purposes.

528. -- 549. (RESERVED).

550. REQUIREMENTS FOR FURNISHING, EQUIPMENT, AND SUPPLIES.

Furnishing, Equipment, and Supplies. Each facility shall provide:

(7-1-99)T

- 01. Living Room Furnishings.** Reading lamps, tables, and comfortable chairs or sofas in living rooms.
(7-1-99)T

02. Resident Sleeping Room Furnishings. Comfortable furnishings and individual storage for personal items for each resident in each sleeping room.
(7-1-99)T

03. Resident Bed. Each resident with his own bed, which shall be at least thirty-six (36) inches wide, substantially constructed, and in good repair. Roll-away beds, cots, folding beds, or double bunks shall be prohibited. Each bed shall be provided with springs which are in good repair, a clean and comfortable mattress which is standard for the bed, and a pillow.
(7-1-99)T

04. Drinking Glasses. Clean drinking glasses for resident use. Common drinking glasses shall be prohibited.
(7-1-99)T

05. Resident Telephone Privacy. A telephone in the facility which is accessible to all residents. The telephone shall be situated in such a manner so as to provide the resident adequate privacy while using the telephone.
(7-1-99)T

06. Basic Services And Supplies. Room, board, activities of daily living services, supervision, assistance and monitoring of medications, linen, towels, wash cloths, soap, shampoo, comb, hairbrush, toilet paper, sanitary napkins, first aid supplies, electric razors or other means of shaving, toothbrush, toothpaste, laundering of linens owned by the facility, emergency transportation, housekeeping services, maintenance, utilities, and basic T.V. in common areas shall be included in the basic room and board charges and must be available at no extra charge.
(7-1-99)T

551. -- 673. (RESERVED).

674. MENTAL HEALTH CONTRACT BEDS.

Facilities may enter into agreements with the Department to provide short-term care to certain residents designated by the mental health program of the Department. These residents are temporarily distressed and unable to fully meet their basic needs. They require strong support, supervision, and while nonviolent or a danger to self or others, could regress without these supports. The following conditions must be met by the facility:
(7-1-99)T

01. License And Personnel. The facility is on a full license and is staffed with at least one (1) staff member up and awake at night to assure the safety of all residents.
(7-1-99)T

02. Written Contract. The facility has a written contract with the Department outlining the responsibilities of both parties and lists the names and telephone numbers of individuals who may be contacted if questions arise regarding the residents' care.
(7-1-99)T

03. Resident Assessment. The facility has on file the results of an assessment which clearly assures that the resident is not a danger to himself or others.
(7-1-99)T

04. Personnel Orientation And Training. Personnel providing direct resident care shall have documented evidence on file at the facility of appropriate orientation and training in providing care for residents in the mental health program.
(7-1-99)T

675. HOURLY ADULT CARE.

- 01. Policies.** Policies governing the acceptance of individuals to the hourly adult care program shall be

developed and implemented and shall provide at least the following: (7-1-99)T

- a. Types of individuals who may not be accepted; (7-1-99)T
- b. Health and other pertinent information regarding the individual's needs; (7-1-99)T
- c. Emergency telephone numbers for contact with family members or physician and other identification information; and (7-1-99)T
- d. Written policies shall be available to participants, families and general public. (7-1-99)T

02. Hourly Adult Care Operation. Policies shall be developed and implemented governing the operation of the hourly adult care program and shall include at least the following: (7-1-99)T

- a. Time periods of program not to exceed fourteen (14) consecutive hours in a twenty-four (24) hour period; (7-1-99)T
- b. Cost of program to resident; (7-1-99)T
- c. A description of services offered, including, but not limited to meals, activities, transportation services, if offered, and supervision; and (7-1-99)T
- d. Records required. (7-1-99)T

03. Medications. (7-1-99)T

- a. The facility shall not admit residents to the hourly adult care program who cannot administer their own medications. See Subsection 010.47; (7-1-99)T
- b. Each hourly adult care resident shall be responsible for bringing his own supply of medications for the stay; and (7-1-99)T
- c. The facility shall be responsible for the safeguarding of the hourly adult care resident's medications while he is at the facility. (7-1-99)T

04. Records. (7-1-99)T

- a. The facility shall maintain a record for each hourly adult care resident which includes at least admission identification information including responsible party and physician; (7-1-99)T
- b. The facility shall maintain a record for each hourly adult care resident which includes at least pertinent health and social information relevant to the supervision of the resident; (7-1-99)T
- c. A log of hourly adult care participants shall be maintained for at least the previous year. (7-1-99)T

05. Restrictions. (7-1-99)T

- a. Hourly adult care services may be provided to such number of individuals that the facility can handle without interference with the normal activities of the facility; (7-1-99)T
- b. Provision of time appropriate accommodations shall be made available for the participant, to include, but not be limited to, napping furniture for day time hours, 6 a.m. through 10 p.m., such as lounge chairs, recliners, and couches; (7-1-99)T
- c. The facility shall have the ability to space napping furniture at least three (3) feet apart if needed or requested; (7-1-99)T

- d. Beds and bedrooms shall be available for the sleeping hours when needed by the hourly adult care resident. This bed will not be counted as a licensed bed if resident sleeps over; (7-1-99)T
- e. Beds, and bedrooms of residents shall not be utilized; and (7-1-99)T
- f. No individual shall be admitted to the hourly adult care program who requires skilled nursing or intermediate care or for whom the facility cannot adequately provide services and supervision. (7-1-99)T

676. -- 699. (RESERVED).

700. SPECIALIZED CARE UNITS/FACILITIES FOR ALZHEIMER/DEMENTIA RESIDENTS.

The facility or unit caring for Alzheimer/Dementia residents shall meet the requirements of Rules For Licensed Residential and Assisted Living Facilities In Idaho, Sections 000 through Section 699 and Sections 900 through 999. (7-1-99)T

01. Type Of Facility Required To Meet Specialized Requirements. All facilities, who have a Level III resident with a diagnosis of Alzheimer or an equivalent dementing illness shall meet the requirements for the Specialized Care Units/Facilities For Alzheimer/Dementia Residents, Section 700. (7-1-99)T

02. Policy. Specialized residential care and assisted living units/facilities are specifically designed, dedicated, and operated to provide the individual with chronic confusion, or dementing illness, or both, with the maximum potential to reside in a secure residential environment through the provision of a supervised life-style which is safe, structured but flexible, stress free, and encourages physical activity through a well developed activity and recreational program. The program constantly strives to enable residents to maintain the highest practicable physical, mental or psychosocial well-being. (7-1-99)T

03. Services. Habilitation services, activity program, and behavior management shall be provided to meet the needs of the resident according to their individualized negotiated service agreement. (7-1-99)T

04. Additional Licensure Requirements. A written program of care to be offered by the special care unit/facility shall be developed to include, but not be limited to: (7-1-99)T

- a. A description of the resident population to be served; (7-1-99)T
- b. A statement of philosophy, objectives, and beliefs upon which decisions will be made regarding the special care unit/facility and the expected results; (7-1-99)T
- c. A description of the admission and discharge criteria; (7-1-99)T
- d. A description of security systems; (7-1-99)T
- e. Policies and procedures developed for the specialized unit/facility; (7-1-99)T
- f. A proposed staffing pattern; (7-1-99)T
- g. A plan for specialized personnel training; and (7-1-99)T
- h. A description of programs for activities and social services. (7-1-99)T

05. Personnel Orientation. Each facility offering specialized care units/facilities for Alzheimer/Dementia residents shall develop an orientation training program, for personnel providing care and supervision to these residents, to include, but not be limited to, the following: (7-1-99)T

- a. Alzheimer and Dementia; (7-1-99)T
- b. Symptoms and behaviors of memory impaired people; (7-1-99)T

- c. Communication with memory impaired people; (7-1-99)T
- d. The resident's adjustment to residency in the special care unit/facility; (7-1-99)T
- e. Inappropriate and problem behavior of special care unit/facility residents and appropriate personnel interventions; (7-1-99)T
- f. Activities of daily living for special care unit/facility residents; and (7-1-99)T
- g. Stress reduction for special care unit/facility personnel and resident. (7-1-99)T

06. Orientation Training. Personnel shall have at least six (6) additional hours of orientation training prior to providing unsupervised service. (7-1-99)T

07. Continuing Training. An additional two (2) hours of the required eight (8) hours per year of continuing training shall be in the provision of services to resident's with Alzheimer's disease or dementia disorders. (7-1-99)T

08. Admission Policy. Each facility offering special care units/facilities for Alzheimer/Dementias shall develop and implement a written admission policy governing the acceptance of individuals into the unit/facility. The written policy shall include, but not be limited to the following: (7-1-99)T

a. All residents shall be evaluated by their primary physician for the resident's appropriateness for placement into a secure residential environment prior to admission. The facility shall obtain a written statement from the physician stating that the resident is appropriate for admission prior to the resident's admission; (7-1-99)T

b. Clients of the Department shall also have an assessment from the Department, for the resident's appropriateness for placement into a secure residential environment of the special care unit/facility prior to admission. The facility shall obtain from the Department a written statement that the resident is appropriate for admission prior to the resident's admission; (7-1-99)T

c. The facility shall not admit any resident without a written statement from the resident's primary physician for private-pay residents and from the Department for clients of the Department that the resident's degree/ stage of confusion/dementia is appropriate for the level of services that the facility is licensed to provide; (7-1-99)T

d. No resident shall be admitted whose safety cannot be assured by the appropriate combination of personnel and facility design. (7-1-99)T

e. Residents shall be at a stage of their disease such that only periodic professional observation and evaluation are required; and (7-1-99)T

f. The facility administrator/personnel shall immediately report to the resident's attending physician for private-pay residents and to the Department for Department clients any sudden or significant change in orientation and behavior, especially wandering, which may indicate the need for a more secure environment. The resident shall be re-evaluated by their primary physician for private-pay residents and by the Department for Department clients for progression of the resident's dementia requiring transfer to a facility with greater supervision and security. (7-1-99)T

09. Medications. (7-1-99)T

a. Psychotropic/behavioral modifying medication intervention shall be used as a last recourse only and at the lowest effective dosage. Prior to the facility obtaining physician orders for psychotropic/behavior modifying medication, the facility shall implement a less restrictive systematic non medication, behavioral management, approach to assist and redirect the resident to control his behavior. (7-1-99)T

b. The facility shall ensure that physician orders for psychotropic/behavioral modifying medications are ordered for a specific condition as diagnosed and documented in the medical record, at the lowest possible dosage

and for a duration not to exceed a six (6) month period. At the end of the six (6) month period, the need for the medication and the current dosage shall be reassessed by the resident's physician for possible dose reduction and discontinuation of the medication. The facility shall have written documentation, signed and dated by the physician and consultant pharmacist regarding his reassessment and determinations, in the resident's medical record. (7-1-99)T

10. Behavioral Management. The resident with inappropriate behaviors shall be evaluated with appropriate documentation for each incident of inappropriate behavior to determine the following: (7-1-99)T

- a. Baseline to determine the intensity, duration, and frequency of the inappropriate behavior; (7-1-99)T
- b. Study of antecedent behaviors and activities; (7-1-99)T
- c. Identification of recent changes or additional risk factors in the resident's life; (7-1-99)T
- d. Environment factors such as time of day, personnel involved, noise, levels; (7-1-99)T
- e. Medical status; (7-1-99)T
- f. Staffing patterns at times of inappropriate behavior; (7-1-99)T
- g. Alternative, structured activities or behaviors that have been successful or unsuccessful for the resident in the past; and (7-1-99)T
- h. Effectiveness of behavioral management approaches. (7-1-99)T

11. Safety. (7-1-99)T

a. The unit/facility shall have available an outside area or yard that assures the safety of the residents. Areas are to be fenced/walled, gates are to be easily operable to public and personnel, plants are to be non-hazardous for human contact/consumption and adequate personnel will be present. (7-1-99)T

b. Procedures shall be written and implemented, outlining the steps to be taken by personnel when a resident is discovered to be missing from the unit/facility. (7-1-99)T

c. Procedures shall be written and implemented, outlining precautions to be taken when hazardous cleaning materials or potentially dangerous mechanical equipment is being used in the unit/facility. (7-1-99)T

d. Procedures shall be written and implemented, outlining the steps to be taken by personnel when a resident's behavior becomes uncontrollable. (7-1-99)T

701. -- 899. (RESERVED).

900. IMPOSITION OF ENFORCEMENT REMEDIES.

01. Recommendation Of Remedy. In determining which remedy to recommend, the Department shall consider the facility's compliance history, change of ownership, the number of deficiencies, scope and severity of the deficiencies. Subject to these considerations, the Department may impose any of the remedies described in Subsections 150.01.a through 150.01.g. (7-1-99)T

02. Immediate Jeopardy. If the Department finds that the facility's deficiency or deficiencies immediately jeopardize the health or safety of its residents, the Department shall: (7-1-99)T

a. Appoint temporary management and impose one (1) or more of the remaining remedies specified in Subsections 150.01.a. through 150.01.g.; and (7-1-99)T

b. Summarily suspend the facility's license. (7-1-99)T

03. No Immediate Jeopardy. If the licensing agency finds that the facility's deficiency or deficiencies do not immediately jeopardize resident health or safety, the Department may impose one (1) or more of the remedies specified in Subsections 150.01.a. through 150.01.d. and 150.01.f. and 150.01.g. (7-1-99)T

04. Repeated Noncompliance. If the licensing agency makes a determination of repeated noncompliance with respect to a facility the licensing agency may impose any of the remedies listed in Subsections 150.01.a. through 150.01.g. The licensing agency shall monitor the facility on-site on an as needed basis, until the facility has demonstrated to the licensing agency's satisfaction that it is in compliance with all program requirements governing the facility and that it will remain in compliance. (7-1-99)T

05. Failure To Comply. If a facility has not complied with any program requirement within three (3) months of the date the facility is found to have been out of compliance with such requirement, or as stated in the facility accepted plan of correction and the Department has verified, via on-site resurveys, that the facility has made little or no progress in correcting deficiencies then the Department shall institute a revocation action against the facility. (7-1-99)T

901. -- 924. (RESERVED).

925. ENFORCEMENT REMEDY OF BAN ON ALL ADMISSIONS.

The licensing agency shall notify the facility via certified mail banning all admissions to the facility pending satisfactory correction of all deficiencies. Such bans to the facility or to any part thereof shall remain in effect until the licensing agency determines that the facility has achieved full compliance with all program requirements, or until a substitute remedy is imposed. (7-1-99)T

926. ENFORCEMENT REMEDY OF BAN ON ADMISSIONS OF RESIDENTS WITH SPECIFIC DIAGNOSIS.

The licensing agency shall notify the facility via certified mail when banning admission of all residents with a specific diagnosis. Such bans may be imposed for all prospective residents both state and private, and shall prevent the facility from admitting the kinds of resident it has shown an inability to provide adequate care for. (7-1-99)T

927. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

01. Civil Monetary Penalties. Civil monetary penalties shall be based upon one (1) or more findings of noncompliance. Actual harm to a resident or residents need not be shown. Nothing shall prevent the Department from imposing this remedy for deficiencies which existed prior to the survey or complaint investigation through which they are identified. A single act, omission or incident shall not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule. In such cases, the single highest class of deficiency shall be the basis for penalty. Compliance by the facility at a later date shall not result in the reduction of the penalty amount. If the facility appeals the imposition of the civil monetary penalty, they must post a bond equivalent to the amount of the civil monetary penalty. The three (3) classes of deficiencies upon which civil monetary penalties shall be based are as follows: (7-1-99)T

a. Class A: A deficiency or combination of deficiencies which places one (1) or more residents at substantial risk of serious physical or mental harm; (7-1-99)T

b. Class B: A deficiency or combination of deficiencies, other than Class A deficiencies, which have a direct adverse affect on the health, safety, welfare, or rights of residents; (7-1-99)T

c. Class C: A deficiency, or combination of deficiencies other than A or B deficiencies, which are likely to have an adverse affect on the health, safety, welfare, or rights of residents. (7-1-99)T

02. Amount Assessment Of Civil Monetary Penalty. When civil monetary penalties are imposed, such penalties shall be assessed for each day the facility is or was out of compliance. The amounts below shall be multiplied by the total number of beds according to the records of the state licensing agency at the time of the survey. Penalties shall be imposed for each class of deficiencies identified in a survey or complaint investigation. (7-1-99)T

a. Class A Initial Deficiency is eight dollars (\$8); Class A Repeat Deficiency is ten dollars (\$10); Class B Initial Deficiency is five dollars (\$5); Class B Repeat Deficiency is eight dollars (\$8); Class C Initial Deficiency is two dollars (\$2); Class C Repeat Deficiency is four dollars (\$4). (7-1-99)T

b. In any ninety (90) day period, the penalty amounts may not exceed the applicable ceiling as described immediately below. The ceiling, initial, or repeat, shall be determined by the category which has the largest percentage of the deficiencies cited in the survey or complaint investigation; (7-1-99)T

c. Ceiling amounts for facilities of three (3) and four (4) bed size are one thousand four hundred forty dollars (\$1440) for an Initial Deficiency; and two thousand eight hundred eighty dollars (\$2880) for a Repeat Deficiency. For facilities from five to fifty (5-50) bed size the ceiling amounts are three thousand two hundred dollars (\$3200) for an Initial Deficiency; and six thousand four hundred dollars (\$6400) for a Repeat Deficiency. For facilities from fifty one to one-hundred (51-100) bed size the ceiling amount for an Initial Deficiency is five thousand four hundred dollars (\$5400); and ten thousand eight hundred dollars (\$10,800) for a Repeat Deficiency. For facilities from one hundred and one to one hundred and fifty (101-150) bed size the ceiling amount for an Initial Deficiency is eight thousand eight hundred dollars (\$8800); and seventeen thousand six hundred dollars (\$17,600) for a Repeat Deficiency. For facilities from one hundred and fifty one (151) or more the ceiling amount is fourteen thousand six hundred (\$14,600) for an Initial Deficiency; and twenty nine thousand two hundred (\$29,200) for a Repeat Deficiency. (7-1-99)T

03. Imposing Civil Monetary Penalties. Civil monetary penalties shall be imposed as follows: (7-1-99)T

a. Upon its discovery of a deficiency, the licensing agency shall deliver to the Department, within a period, not to exceed thirty (30) calendar days, its recommendation for assessment of a penalty as a result of such deficiency; and (7-1-99)T

b. The penalty shall be assessed by the Director. (7-1-99)T

04. Notice Of Civil Monetary Penalties. The Department shall give written notice to the facility of its imposition of any such penalty within a period not to exceed thirty (30) days of its receipt of a recommendation by the state licensing agency for the assessment of a penalty. The notice shall inform the facility of the amount of the penalty, the basis for its assessment and the facility's appeal rights. (7-1-99)T

05. Payment Of Penalties. Within thirty (30) calendar days from the date the notice is received by the facility, the facility shall pay the full amount of the penalties unless the facility requests administrative review of the decision to assess the penalty or penalties. The amount of a civil monetary penalty determined through administrative review shall be paid within thirty (30) calendar days of the facility's receipt of the administrative review decision unless the facility requests an administrative hearing. The amount of the civil monetary penalty determined through a hearing shall be paid within thirty (30) calendar days of the facility's receipt of the hearing decision unless the facility files a petition for judicial review. Interest shall be assessed and collected on all unpaid penalties at the legal rate of interest for judgments, as set forth herein. Such assessments shall begin one (1) calendar day after: (7-1-99)T

a. The date of the initial assessment of the penalty; or (7-1-99)T

b. If the facility waives its right to a hearing and opts to pay the penalty, the amount of the civil monetary penalty will be reduced by thirty-five percent (35%). (7-1-99)T

c. The date of issuance of the administrative review, administrative hearing or the final judicial review. (7-1-99)T

06. Collection Of Civil Monetary Penalties. If a facility fails or refuses to pay a penalty within the time required, the Department may impose other penalties or institute a revocation action against the facility. Nothing herein shall prohibit the Department from obtaining judicial enforcement of its right to collect penalties and interest thereon. (7-1-99)T

07. Failure To Pay. Failure of a facility to pay the entire penalty, together with interest, as specified in

Subsection 927.05, shall result in an automatic final decision and no further administrative or judicial review or hearing shall be available to the facility. (7-1-99)T

08. Use Of Civil Monetary Penalties. The Department shall use civil monetary penalties' receipts to protect the health and property of the residents including: (7-1-99)T

- a. Maintenance or operation of a facility pending correction of deficiencies or closure; or (7-1-99)T
- b. Paying costs of relocating residents; or (7-1-99)T
- c. Reimbursing residents for personal funds lost which reimbursement shall not adversely affect a person's Medicaid eligibility. (7-1-99)T

928. ENFORCEMENT REMEDY OF TEMPORARY MANAGEMENT.

01. Need For Temporary Management. The Department shall impose the remedy of temporary management in situations where the licensing agency finds that there is a need to oversee operation of the facility and to assure the health and safety of the facility's residents while there is an orderly transfer of residents of the facility to other facilities or while improvements are made in order to bring the facility into compliance with all program requirements. (7-1-99)T

02. Recommendation For Temporary Management. Within five (5) calendar days of its completion of a survey or complaint investigation, the licensing agency shall deliver to the Director its written recommendation for appointment of temporary management if, in the agency's judgment, such appointment is necessary. The recommendation shall provide the basis for the decision, including the assessment of the capability of the facility's current management to achieve and maintain compliance with all rules. (7-1-99)T

03. Appointment Of Temporary Management. The Director shall appoint temporary management. (7-1-99)T

04. Notice Of Temporary Management. The Department shall give written notice to the facility of its appointment of temporary management within seven (7) calendar days of its receipt of a recommendation for appointment from the state licensing agency, unless the Department determines that temporary management is not necessary. When the licensing agency and Department have determined that the facility deficiency or deficiencies immediately jeopardize the health or safety of its residents, no administrative review shall be required prior to appointment of temporary management and the provisions of Section 951 shall apply. (7-1-99)T

05. Who May Serve As Temporary Manager. The Director may appoint any person or organization which meets the following qualifications: (7-1-99)T

- a. The temporary manager shall not have any pecuniary interest in or preexisting fiduciary duty to the facility to be managed; (7-1-99)T
- b. The temporary manager must not be related, within the first degree of kinship, to the facility's owner, manager, administrator or other management principal; (7-1-99)T
- c. The temporary manager must possess sufficient training, expertise and experience in the operation of a facility as would be necessary to achieve the objectives of temporary management. If the temporary manager is to serve in a facility, the manager must possess an Idaho Residential Care Administrator's license; (7-1-99)T
- d. The temporary manager must not be an existing competitor of the facility who would gain an unfair competitive advantage by being appointed as temporary manager of the facility. (7-1-99)T

06. Powers And Duties Of The Temporary Manager. The temporary manager shall have the authority to direct and oversee the management, hiring and discharge of any consultant or personnel, including the administrator of the facility. The temporary manager shall have the authority to direct the expenditure of the revenues

of the facility in a reasonable, prudent manner, to oversee the continuation of the business and the care of the residents, to oversee and direct those acts necessary to accomplish the goals of the program requirements and to direct and oversee regular accounting, and the making of periodic reports to the licensing agency. The temporary manager shall provide reports no less frequently than monthly showing the facility's compliance status. Should the facility fail or refuse to carry out the directions of the temporary manager, the Department may, at its discretion, impose any other remedies described herein. (7-1-99)T

a. The temporary manager shall observe the confidentiality of the operating policies, procedures, employment practices, financial information, and all similar business information of the facility, except that the temporary manager shall make reports to the state licensing agency as provided in this section; (7-1-99)T

b. The temporary manager shall be liable for gross, willful or wanton negligence, intentional acts of omissions, unexplained shortfalls in the facility's fund, and breaches of fiduciary duty; (7-1-99)T

c. The temporary manager shall be bonded in an amount equal to the facility's revenues for the month preceding the appointment of the temporary manager; (7-1-99)T

d. The temporary manager shall not have authority to cause or direct the facility or its owner, administrator to incur debt or to enter into any contract with a duration beyond the term of the temporary management of the facility; (7-1-99)T

e. The temporary manager shall not have authority to incur, without the permission of the owner, administrator or the Department, capital expenditures in excess of two thousand dollars (\$2,000), unless the capital expenditures are directly related to correcting the identified deficiencies; (7-1-99)T

f. The temporary manager shall not have authority to cause or direct the facility to encumber its assets or receivables, or the premises on which it is located, with any lien or other encumbrances; (7-1-99)T

g. The temporary manager shall not have authority to cause or direct the facility to cancel or reduce its liability or casualty insurance coverage; (7-1-99)T

h. The temporary manager shall not have authority to cause or direct the sale of the facility, its assets or the premises on which it is located. (7-1-99)T

07. Responsibility For Payment Of The Temporary Manager. All compensation and per diem costs of the temporary manager shall be paid by the facility. The Department shall bill the facility for the costs of the temporary manager after termination of temporary management. The costs of the temporary manager for any thirty (30) day period shall not exceed one-sixth (1/6) of the maximum allowable administrator's annual salary for the largest facility. Within fifteen (15) calendar days of receipt of the bill, the facility shall pay the bill or request administrative review to contest the costs for which it was billed. (7-1-99)T

08. Termination Of Temporary Management. A temporary manager may be replaced under the following conditions: (7-1-99)T

a. The Department may replace any temporary manager whose performance is deemed unsatisfactory by the Department. No formal procedure is required for such removal or replacement but written notice of any action shall be given to the facility, including the name of any replacement manager. (7-1-99)T

b. The Department shall not terminate temporary management until it has reasonable assurances that the facility has management capability to ensure continued compliance with all rules. (7-1-99)T

c. A facility subject to temporary management may petition the Department for replacement of a temporary manager whose performance it considers unsatisfactory. The petition shall include why the replacement of a temporary manager is necessary or appropriate. The Department shall respond to a petition for replacement within five (5) calendar days after receipt of said petition. (7-1-99)T

929. ENFORCEMENT REMEDY OF SUMMARY SUSPENSION AND TRANSFER OF RESIDENTS.

01. Summarily Suspend The Facility's License And Transfer Residents. The licensing agency may summarily suspend a facility's license and transfer residents when residents' health and safety are in immediate jeopardy. See Section 111, Subsection 929.02 and Section 971. (7-1-99)T

02. Emergency Powers Of The Director. In the event of an emergency endangering the life or safety of a resident, the Director may summarily suspend or revoke any facility license. As soon thereafter as practicable, the Director shall provide an opportunity for a hearing. (7-1-99)T

930. ENFORCEMENT REMEDY OF PROVISIONAL LICENSE.

Facilities found to be in substantial compliance with this chapter but failing to comply in every detail may be issued a provisional license. See Subsections 126.03.a. and 126.03.b. (7-1-99)T

931. ENFORCEMENT REMEDY OF REVOCATION OF LICENSE.

01. Revoke The Facility's License. The Department may institute a revocation action when the facility is not in substantial compliance with this chapter. (7-1-99)T

02. Causes For Revocation. The licensing agency may revoke any license: (7-1-99)T

a. The license holder has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license; (7-1-99)T

b. The facility is not in substantial compliance with these rules; (7-1-99)T

c. When persuaded by a preponderance of the evidence that such conditions exist which endanger the health or safety of any resident; (7-1-99)T

d. Any act adversely affecting the welfare of residents is being permitted, aided, performed, or abetted by the person or persons in charge of the facility. Such acts may include, but are not limited to, neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; (7-1-99)T

e. The license holder has demonstrated or exhibited a lack of sound judgment essential to the operation and management of a facility; (7-1-99)T

f. The license holder has violated any of the conditions of a provisional license; (7-1-99)T

g. The facility has one (1) or more major deficiencies. A major deficiency is a deficiency that endangers the health or safety or welfare of any resident; (7-1-99)T

h. An accumulation of minor violations that taken as a whole would constitute a major deficiency as noted in Subsection 931.02.g.; (7-1-99)T

i. Repeat violations of any requirement of these rules or of the Idaho Code; (7-1-99)T

j. The facility lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of residents residing at the facility; and (7-1-99)T

k. The facility is not in substantial compliance with the provisions for services or residents' rights outlined in Subsection 101.04.d., Section 250 through Subsection 251.03.e. (7-1-99)T

l. License holder refuses to allow the licensing agency or the Protection and Advocacy agencies described in Subsection 250.13 full access to the facility environment, facility records, and the residents. (7-1-99)T

932. ENFORCEMENT REMEDY OF INJUNCTION.

Notwithstanding any other remedy at law, the Director may seek an injunction in the name of the state against any

person or governmental unit to enjoin the establishment, conduct, management, or operation of a facility in violation of the provisions of this chapter. See Sections 39-3358, 39-3380, 39-3558, and 39-3570, Idaho Code. (7-1-99)T

933. -- 949. (RESERVED).

950. RIGHT TO SELL.

Nothing contained in Section 150 shall limit the right of any facility owner to sell, lease, mortgage, or close any facility in accordance with all applicable laws. (7-1-99)T

951. NOTICE OF ENFORCEMENT REMEDY.

The Department shall give notice of the imposition of any remedy described in this chapter after the facility is afforded any allowable reviews or hearings as follows: (7-1-99)T

01. Notice To Facility. The Department shall give notice to the facility in writing, transmitted in a manner which shall reasonably ensure timely receipt by the facility such as certified mail or personal delivery; and (7-1-99)T

02. Notice To Public. The Department shall give notice to the public by transmitting printed notices to the facility. The facility shall post all notices where they can reasonably be expected to be read by the facility's residents or their representatives, including, but not limited to, exits and common areas. The notices shall remain in place until all remedies are officially removed by the licensing agency. Failure of a facility to comply with notice posting requirements shall constitute a Class B deficiency; and (7-1-99)T

03. Notice To The Ombudsman. The Department shall give notice to the state Ombudsman for the elderly; and (7-1-99)T

04. Notice To The Resident's Attending Physicians. The Department shall give notice to the attending physician of each resident affected by a finding of substandard quality of care; and (7-1-99)T

05. Notice To The Professional Licensing Boards. The Department shall give notice to professional licensing boards, as appropriate; and (7-1-99)T

06. Failure To Effect Notice. Failure of the Department to effect notice as required in Section 951 through Subsection 951.06 shall not be grounds for the facility to contest any action taken under this chapter. (7-1-99)T

952. -- 969. (RESERVED).

970. PROCEDURE FOR HEARINGS FOR ENFORCEMENT ACTIONS AGAINST A LICENSE.

01. Facility Notification. Immediately upon the decision to implement an enforcement action to include denial of license, the licensing agency shall notify the applicant or administrator in writing by certified mail or by personal service of its decision to implement an enforcement action against the license and the reason for the enforcement action. (7-1-99)T

02. Administrative Review. The notification of denial or revocation shall also offer the applicant or the administrator the opportunity to request an administrative review. Should the facility wish to contest imposition of a remedy, other than a plan of correction and except as provided in Subsections 927.05 and 928.04, a written request for administrative review must be received by the Department within fourteen (14) calendar days of the facility's receipt of notice of imposition of the remedy. The request shall state the grounds for its contention that the imposition of a remedy is in error. (7-1-99)T

a. During this conference, the position of the Department and the facility may be discussed and if possible an alternative to revocation or denial developed. (7-1-99)T

b. The Department shall transmit printed notice of administrative review to the facility. Such notices shall set forth date, time and location whenever the facility has requested and been granted a review on imposition of

a remedy. The facility shall post all notices so provided. The notices shall be placed in areas readily accessible and visible to residents and their representatives. (7-1-99)T

c. The Department shall issue a written decision within fourteen (14) calendar days of the completion of the facility's receipt of the administrative review. The review shall be made solely on the basis of the licensing agency recommendation, the survey report, the statement of deficiencies, any documentation the facility submits to the Department at the time of its request, and information received as a result of the administrative review process. For the purposes of such review, a hearing shall not be held and oral testimony shall not be taken. (7-1-99)T

d. If the facility fails to file a timely request, the decision to impose a remedy or remedies shall become final and no further hearing or judicial review shall be available. (7-1-99)T

03. Administrative Hearing. Should the facility wish to appeal the administrative review decision for remedies described in Section 150 through 150.01 subject to the limitations therein, it may request an administrative hearing in accordance with the provisions of IDAPA 16.05.03, Section 311, et seq., "Rules Governing Contested Cases Proceedings and Declaratory Rulings". The scope of the administrative hearing shall be limited to issues raised and meaningfully addressed in the administrative review. (7-1-99)T

a. If the Department has imposed temporary management pursuant to the provisions of Section 928 or imposed either of the remedies specified in Subsection 150.01.e., the facility shall be entitled to a hearing which shall commence not less than five (5) nor more than ten (10) calendar days after the facility's receipt of notice of imposition of said remedy or remedies. No administrative review shall be conducted in such cases and no request for hearing shall be required. A facility may waive its right to a hearing by written notice to the licensing agency. (7-1-99)T

b. Except in the cases of appointment of a temporary manager, unless the Department has determined that immediate jeopardy to the health or safety of a facility's residents exists, transfer of residents of a facility or payment of civil monetary penalties, the imposition of remedies shall not be stayed during the pendency of any hearing. (7-1-99)T

971. TRANSFER OF RESIDENTS.

The Department may transfer residents from a facility to an alternative placement on the following grounds: (7-1-99)T

01. Violation Of Rules. As a result of a violation of a provision of the rules or standards, the facility is unable or unwilling to provide an adequate level of meals, lodging, personal assistance, or supervision to persons residing in the facility at the time of the violation. (7-1-99)T

02. Violation Of Resident's Rights. A violation of a resident's rights provided in Sections 39-3316, 39-3387, 39-3516, 39-3576, or a combination, Idaho Code. (7-1-99)T

03. Exceed Licensed Bed Capacity. The number of residents currently in the facility exceeds the number of residents the facility is licensed to serve. (7-1-99)T

04. Unlicensed. The facility is operating without a license. (7-1-99)T

05. Imminent Danger. A violation of a provision of this chapter or applicable rules or standards results in conditions that present an imminent danger. (7-1-99)T

972. -- 995. (RESERVED).

996. ADMINISTRATIVE PROVISIONS.

Contested case appeals are governed by IDAPA 16.05.03, Section 311 et seq., "Rules Governing Contested Cases Proceedings and Declaratory Rulings". (7-1-99)T

997. CONFIDENTIALITY OF RECORDS.

Any disclosure of information obtained by the Department is subject to the restrictions contained in IDAPA 16.05.01,

"Rules Governing the Protection and Disclosure of Department Records".

(7-1-99)T

998. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.12 - RULES GOVERNING THE INDIVIDUAL AND FAMILY GRANT PROGRAM

DOCKET NO. 16-0412-9901

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2000 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 56-202b; 39-106(l), Idaho Code.

DESCRIPTIVE SUMMARY: The pending rules are being adopted as proposed. The original text of the proposed rules was published in the May 5, 1999 Administrative Bulletin, Volume 99-5, pages 70 and 71.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Patti Campbell at (208) 334-5815.

DATED this 21st day of June, 1999.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
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IDAPA 16
TITLE 04
Chapter 12

RULES GOVERNING THE INDIVIDUAL AND FAMILY GRANT PROGRAM

**There are no substantive changes
from the proposed rule text.**

**The original text was published in the Idaho
Administrative Bulletin, Volume 99-5, May 5, 1999,
pages 70 and 71.**

**This rule has been adopted as Final by the Agency
and is now pending review by the
2000 Idaho State Legislature for final adoption.**

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE

18.01.26 - MANAGED CARE REFORM ACT

DOCKET NO. 18-0126-9901

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

August 26, 1999 - 9:30 a.m.
Idaho Department of Insurance, J.R. Williams Building
700 W. State Street, 3rd Floor, Boise, ID 83720

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Adds a new section clarifying the Department's interpretation of Sections 41-3904 and 41-3927, Idaho Code and provide examples with the Department's position as to each. Provides a definition for the term "Any Willing Provider Law".

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Joan A. Krosch at (208) 334-4300.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before August 26, 1999.

Dated this 23rd day of June, 1999.

Mary L. Hartung, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THE FOLLOWING IS TEXT OF DOCKET NO. 18-0126-9901

004. DEFINITIONS.

01. The Act. All terms defined in the Act which are used in this rule shall have the same meaning as used in the Act. (7-1-98)

02. Any Willing Provider Law. As used in this rule, the term "Any Willing Provider Law" refers to the provisions of Section 41-3927, Idaho Code, that require a MCO to be ready and willing to contract with any provider

- that: ()
- a. Is qualified under Idaho law; ()
 - b. Desires to participate as a provider; ()
 - c. Meets the requirements of the organization; and ()
 - d. Practices within the general area served by the organization as such provisions are more fully set forth in the statute. ()

023. Balance Billing. An organized system of health care providers and providers who accept referrals from the Managed Care Organization are prohibited from balance billing individuals. Balance billing refers to the practice whereby a provider bills an individual covered under the benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the service delivered. (7-1-98)

034. Director. The term, Director, as referred to in this rule, shall mean the Director of the Department of Insurance, State of Idaho. NOTE: Senate Bill No. 1294, effective July 1, 1974, created the position of Director of the Department of Insurance to be the chief executive officer of that department and to assume the duties of the previous Commissioner of Insurance. (7-1-98)

045. MCO. Managed Care Organizations shall be abbreviated to MCO in this rule. (7-1-98)

056. MCO Provider. MCO provider means any provider owned, managed, employed by, or under contract with an MCO to provide health care services to MCO members. An MCO provider includes a physician, hospital, or other person licensed or otherwise authorized to furnish health care services. (7-1-98)

(BREAK IN CONTINUITY OF SECTIONS)

017. --999. (RESERVED) APPLICATION OF "ANY WILLING PROVIDER LAW".

01. Requirements Of The MCO. A MCO is not required to contract with a provider who does not meet the material requirements of the organization's participating provider contracts. If the MCO's provider contract(s) require(s) the provision of an array of services, then any provider seeking to contract with the MCO as a willing provider must be willing and able to provide all such required services. If a prospective provider is unable to provide the services required under the existing provider contract(s), the provider has not met the MCO's requirements per Section 41-3927(1), Idaho Code. Other "requirements" of the MCO that must be met prior to the satisfaction of the prerequisites within the Any Willing Provider Law are material contractual terms, such as cost, geographic area or scope, and time deadlines. Any requirement imposed by a MCO for the purpose of avoiding the requirements of the Any Willing Provider Law will not be construed as a permissible "requirement" for purposes of Section 41-3927, Idaho Code. ()

02. Non-Licensed Entities. Under Section 41-3904(4), Idaho Code, an entity not required to hold a MCO certificate of authority, but which holds itself out as providing basic health care services, is subject to the Any Willing Provider Law. However, these entities are not subject to regulation by the department. ()

03. Related Laws. While this section explicitly applies to the MCO context in the Any Willing Provider Law, it may be used as guidance in application of the "any willing provider" provisions at Sections 41-1844 and 41-2872, Idaho Code. ()

04. Examples. Without limitation, the following are examples of how the Any Willing Provider Law applies to various fact situations. It is assumed that the contract terms or requirements are legitimate and not mandated for the purpose of avoiding the Any Willing Provider Law. ()

a. A MCO contracts directly with providers and provider networks. A qualified individual provider seeks to contract with the MCO, and is willing to accept the same terms as provided under existing contracts with other similar providers. The MCO is required to contract with the individual provider. ()

b. A MCO contracts directly with providers and provider networks. A provider group seeks to contract with the MCO. The provider group is qualified under Idaho law and is willing and able to offer the same services under the same terms as provided under an existing contract with another provider network. The MCO is required to contract with the provider group. ()

c. A MCO contracts only with one or more provider networks. It does not contract directly with individual providers. A qualified individual provider offers to contract with the MCO upon the same terms as individual providers that contract with the MCO's provider network. The MCO is not required to contract with the individual provider since the provider is not offering to contract on the same terms as the existing provider agreement between the MCO and the provider network. ()

d. A MCO contracts only with one (1) or more provider networks. It does not contract directly with individual providers. Another qualified provider group offers to contract with the MCO on the same terms as the existing network contract, and is able to offer the same categories of services as provided for under the existing contract. The MCO is required to contract with the provider group. ()

e. A provider network not licensed as a MCO contracts with a MCO to provide the MCO's subscribers "basic health care services", as defined at Section 41-3903(1), Idaho Code. The provider network, in turn, enters into contracts for services with individual providers or provider groups. A qualified individual provider or provider group offers to contract with the network upon the same terms as contained in the network's existing contracts with other similar providers or provider groups. The network is subject to the Any Willing Provider Law and required to contract with the provider or provider group. However, the Department cannot force the network to comply with the Any Willing Provider Law because the network is not subject to regulation by the Department. ()

018. -- 999. (RESERVED).

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.69 - RULE TO IMPLEMENT THE SMALL EMPLOYER HEALTH
INSURANCE AVAILABILITY ACT

DOCKET NO. 18-0169-9901

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 1999.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency at the address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Removes language making Small Employer Health Insurance Availability Act provisions applicable to those holding individual policies where premium is paid by employer in whole or part and removes prohibition directed at agents and brokers. Removes obsolete provisions concerning small employer health benefit plans. Provides updates to various citations.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Joan A. Krosch at (208) 334-4300.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before August 25, 1999.

Dated this 23rd day of June, 1999.

Mary L. Hartung, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THE FOLLOWING IS TEXT OF DOCKET NO. 18-0169-9901

015. APPLICABILITY.

01. Applicability. ~~Except as provided in Subsection 015.02 and Section 091, (1-25-95)()~~ This rule shall apply to any health benefit plan, whether provided on a group or individual basis, which: (1-25-95)()

a. Meets one (1) or more of the conditions set forth in Sections 41-4704(1) through 41-4704(4), Idaho Code; (1-25-95)

b. Provides coverage to two (2) or more eligible employees of a small employer located in this state,

without regard to whether the policy or certificate was issued in this state; and, (1-25-95)

c. Is in effect on or after the effective date of the Act. (1-25-95)

~~02. **Exceptions.** The provisions of this Rule shall not apply to an individual health benefit plan delivered or issued for delivery prior to 4/1/94. (1-25-95)~~

~~03. **Individual Health Benefit Plans Subject To Provisions Of The Act And This Rule.** A carrier that provides individual health benefit plans to two (2) or more of the eligible employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of the Act and this Rule with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware of such contribution. Agents and brokers are prohibited, at risk of losing their license, from arranging individual health benefit plans which they know to be supported financially by an employer. (1-25-95)~~

~~04. **Provisions That Would Subject Individual Health Plans To The Act And This Rule.** In the case of a carrier that provides individual health benefit plans to two (2) or more eligible employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in Section 41-4708(1)(e), Idaho Code, and the small employer carrier shall be subject to Section 41-4708(1)(b), Idaho Code, relating to guaranteed issue of coverage, if: (1-25-95)~~

~~a. The small employer has at least two (2) eligible employees; (1-25-95)~~

~~b. The small employer contributes as defined in Section 41-4704, Idaho Code; and; (1-25-95)~~

~~e. The carrier is aware of the contribution by the employer. (1-25-95)~~

~~052. **Group Policy Or Trust Arrangement.** The provisions of the Act and this Rule shall apply to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group unless such health benefit plan(s) are subject to Title 41, Chapter 52, Idaho Code. (1-25-95)()~~

~~06. **Deduction Under Section 162(1), Internal Revenue Code.** An individual health benefit plan shall not be subject to the provisions of the Act and this Rule solely because the policyholder elects a deduction under Section 162(1), Internal Revenue Code. (1-25-95)~~

~~073. **Subsequent Employment Of More Than Fifty Eligible Employees.** If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this Rule shall continue to apply to the health benefit plan in the case that the small employer subsequently employs more than fifty (50) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than fifty (50) eligible employees but no later than the anniversary date of the employer's health benefit plan, notify the employer that the protections provided under the Act and this Rule shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan. (7-1-98)~~

~~084. **Employer Subsequently Becomes A Small Employer.** If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of the Act shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer. (1-25-95)~~

~~095. **Time Period For Notification Of Options To Employer.** A carrier providing coverage to an employer described in Subsection 015.08 shall, within sixty (60) days of becoming aware that the employer has fifty (50) or fewer eligible employees, notify the employer of the options and protections available to the employer under the Act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier. (7-1-98)~~

406. Employees In More Than One State. If a small employer has employees in more than one (1) state, the provisions of the Act and this Rule shall apply to a health benefit plan issued to the small employer if: (1-25-95)

- a. The majority of eligible employees of such small employer are employed in this state; or (1-25-95)
- b. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state. (1-25-95)

407. Laws Of This State Or Another State. In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subsection 015.10, the provisions of the paragraph shall be applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect. (1-25-95)

408. Health Benefit Plan Subject To The Act And This Rule. If a health benefit plan is subject to the Act and this Rule, the provisions of the Act and this Rule shall apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state. (1-25-95)

409. When Is A Small Employer Carrier Not Subject To The Act And This Rule. A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of the Act and this Rule solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state. (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

036. RESTRICTIONS RELATING TO PREMIUM RATES.

01. Separate Rate Manual For Each Class Of Business. A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion. (1-25-95)

02. Requirements For Adjustments To Rating Method. A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this subsection. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this Rule. (1-25-95)

03. Information Required For Review Of Modification Of Rating Method. A carrier may modify the rating method for a class of business only with prior approval of the Director. A carrier requesting to change the rating method for a class of business shall make a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing shall contain at least the following information: (1-25-95)

- a. The reasons the change in rating method is being requested; (1-25-95)
- b. A complete description of each of the proposed modifications to the rating method; (1-25-95)
- c. A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan); (1-25-95)

d. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and (1-25-95)

e. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Section 41-4706, Idaho Code. (1-25-95)

04. Change In Rating Method. For the purpose of Section 036 a change in rating method shall mean: (1-25-95)

a. A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business (a small employer should not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); (7-1-98)

b. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business; (1-25-95)

c. A change in the method of allocating expenses among health benefit plans in a class of business; or (1-25-95)

d. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%). (1-25-95)

e. For the purpose of Subsection 036.04, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test. (1-25-95)

05. Rate Manual To Specify Case Characteristics And Rate Factors To Be Applied. The rate manual developed pursuant to Subsection 036.01 shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business. (1-25-95)

06. Case Characteristics Other Than Age, Individual Tobacco Use, Geography And Gender - Must Have Prior Approval Of Director. A small employer carrier may not use case characteristics other than those specified in Section 41-4706(1)(~~E~~), Idaho Code, without the prior approval of the Director. A small employer carrier seeking such an approval shall make a filing with the Director for a change in rating method under Subsection 036.02. (~~7-1-98~~)()

07. Case Characteristics Shall Be Applied In A Uniform Manner. A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer. (1-25-95)

08. Rate Manual Must Clearly Illustrate Relationship Among Base Premium Rate And Any Difference In New Business Rate. The rate manual developed pursuant to Subsection 036.01 shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference. (1-25-95)

09. Differences In Premium Rates Must Reflect Reasonable And Objective Differences. Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and

are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. (1-25-95)

10. Premium Rates To Be Developed In Two Step Process. The rate manual developed pursuant to Subsection 036.01 shall provide for premium rates to be developed in a two (2) step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-4706, Idaho Code, to reflect the risk characteristics of the group. (1-25-95)

11. Exception To Application Fee, Underwriter Fee, Or Other Fees. Except as provided in Subsection 036.12, a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. (1-25-95)

12. Uniform Application Of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to every health benefit plan in a class of business. All such fees are premium and shall be included in determining compliance with the Act and these Rules. (1-25-95)

13. Uniform Allocation Of Administration Expenses. ~~A small employer carrier shall allocate administrative expenses to the basic, standard, and catastrophic health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business.~~ The rate manual developed pursuant to Subsection 036.01 shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed. (7-1-98)()

14. Rate Manual To Be Maintained For A Period Of Six Years. Each rate manual developed pursuant to Subsection 015.01 shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual. (1-25-95)

15. Rate Manual And Practices Must Comply With Guidelines Issued By Director. The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Director. (1-25-95)

16. Application Of Restrictions Related To Changes In Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-4706(1)(c), Idaho Code, and shall be applied as follows: (1-25-95)

a. A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates. (1-25-95)

b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of Sections 41-4706(1)(c)(ii) and 41-4706(1)(f)(i), Idaho Code. (1-25-95)

c. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Sections 41-4706(1)(c) and (f), Idaho Code. (1-25-95)

d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier shall make a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within thirty (30) days of the beginning of the rating period. (1-25-95)

e. A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period. (1-25-95)

17. Change In Premium Rate. Except as provided in Subsections 036.18 and 036.19, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:(1-25-95)

- a. The base premium rate for the small employer, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by; (1-25-95)
- b. One (1) plus the sum of: (1-25-95)
 - i. The risk load applicable to the small employer during the previous rating period; and (1-25-95)
 - ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (1-25-95)

18. Rating Restrictions On Plans Where Carrier Is No Longer Enrolling New Business. In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by Subsections 036.18.a. and 036.18.b. below. (1-25-95)()

- a. One (1) plus the lesser of: (1-25-95)
 - i. The change in the base rate; or (1-25-95)
 - ii. The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers. (1-25-95)
- b. One (1) plus the sum of: (1-25-95)
 - i. The risk load applicable to the small employer during the previous rating period; and (1-25-95)
 - ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (1-25-95)

~~**19. Plans Written Prior To January 1, 1994.** In the case of a health benefit plan described in Section 41-4706(1)(f), Idaho Code, if the current premium rate for the health benefit plan exceeds the ranges set forth in Section 41-4706, Idaho Code, the formulae set forth in Subsections 036.17 and 036.18 will be applied as if the fifteen (15%) adjustment provided in Subsections 036.17.b.ii. and 036.18.c.ii. were a zero percent (0%) adjustment. (1-25-95)~~

2019. Limitations On Revised Premium Rate. Notwithstanding the provisions of Subsections 036.17 and 036.18, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-4706(1)(b), Idaho Code. (1-25-95)

240. Waiver Request For A Taft-Hartley Trust. A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file a written request with the Director for the waiver of application of the provisions of Section 41-4706(1), Idaho Code, with respect to such trust. (1-25-95)

221. Provisions For Which Trust Is Seeking Waiver. A request made under Subsection 036.21 shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would: (1-25-95)

- a. Adversely affect the participants and beneficiaries of the trust; and (1-25-95)
- b. Require modifications to one (1) or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained. (1-25-95)

232. Waiver Shall Not Apply To Individual Or Associate Member. A waiver granted under this

provision shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual. (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

046. REQUIREMENT TO INSURE ENTIRE GROUPS.

01. Offer Of Coverage. A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in Subsection 046.02, the small employer carrier shall provide the same health benefit plan to each such employee and dependent. (1-25-95)

02. Choice Of Health Benefit Plans. A small employer carrier may offer the employees of a small employer the option of choosing among one or more health benefit plans, provided that each eligible employee may choose any of the offered plans. Except as provided in Section 41-4708(3), Idaho Code, (with respect to exclusions for pre-existing conditions), the choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the eligible employees or their dependents. (1-25-95)

03. Participation Requirement. The small employer carrier may impose reasonable minimum participation requirements for issuance of coverage to small employers, subject to prior approval from the Director. (1-25-95)

04. Employer Census And Supporting Documentation. A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to prepare or provide an employer census of dependents and eligible employees as defined in Sections 41-4703 (123) and (145), Idaho Code. The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) or a certification of information by a Small Employer as to the current census information. (~~1-25-95~~)(____)

05. Waiver For Documentation Of Coverage. A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for a period of six (6) years. (1-25-95)

06. Refusal To Provide Information. A small employer carrier shall not issue coverage to a small employer that refuses to provide the list required under Subsection 046.01 or a waiver required under Subsection 046.05, except for the following: (1-25-95)

a. The excluded individual has coverage under a health benefit plan or other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan. (1-25-95)

07. Small Employer Carrier Shall Not Issue Coverage. A small employer carrier shall not issue coverage to a small employer if the carrier, or an agent for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics. (1-25-95)

08. Agent Notification To Small Employer Carrier. An agent shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics. (1-25-95)

09. New Entrants. New entrants to a small employer group shall be offered an opportunity to enroll in the health benefit plan currently held by such group based upon the provisions of Section 41-4708(3)(~~ba~~), Idaho Code. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of his or her opportunity to enroll. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier to all new enrollees under the Employee Benefit Plan. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to Subsection 046.02, the new entrant shall be offered the same choice of health benefit plans as the other members of the group. (1-25-95)(~~_____~~)

10. Small Employer Carrier Shall Not Apply Waiting Period Or Similar Limitation. A small employer carrier shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for pre-existing medical conditions consistent with Section 41-4708(3)(~~ba~~), Idaho Code. This provision does not preclude application of any waiting periods applicable to all new enrollees under the health benefit plan. (1-25-95)(~~_____~~)

11. No Restrictions Or Limitations On Coverage Related To Risk Characteristics. New entrants to a group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-4708(3)(~~a~~), Idaho Code. (1-25-95)(~~_____~~)

12. Risk Load. A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-4706, Idaho Code. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group. (1-25-95)

~~**13. Open Enrollment.** In the case of an eligible employee (or dependent of an eligible employee) who, prior to the effective date of Section 41-4708, Idaho Code, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer (as defined in Section 41-4708(1)(c), Idaho Code, the small employer carrier shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in the health benefit plan currently held by the small employer. (1-25-95)~~

~~**14. Statement That Coverage Was Not Offered.** A small employer carrier may require an individual who requests enrollment under this subsection to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that the coverage was not offered to the individual. (1-25-95)~~

15. Opportunity To Enroll. The opportunity to enroll shall meet the following requirements: (1-25-95)

a. The opportunity to enroll shall begin October 1st, 1994 and shall last for a period of at least thirty (30) days. (1-25-95)

b. Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subsection shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with Subsection 046.15.e. (1-25-95)

~~e. The terms of coverage offered to an individual described in Subsection 046.13 may exclude or limit, coverage for pre-existing medical conditions if the health benefit plan currently held by the small employer contains such an exclusion or limitation, provided that the exclusion or limitation shall be reduced by the number of days between the date the individual was excluded or denied or limited coverage and the date coverage is provided to the individual pursuant to this subsection. (1-25-95)~~

~~d. A small employer carrier shall provide written notice at least forty five (45) days prior to the opportunity to enroll provided in Subsection 046.13 to each small employer insured under a health benefit plan offered by such carrier. The notice shall clearly describe the rights granted under this subsection to employees and dependents who were previously excluded from or allowed through a rider or limited benefits or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan. (1-25-95)~~

163. Rescission Employer Misstatements. (1-25-95)()

a. When material application misstatements are found, rescission action by the carrier shall be taken at the carrier's option against the coverage of an entire small employer (including employees and dependents) and shall be limited to circumstances under which the application misstatements have been made by the small employer in his or her capacity as an employer. When rescission action is taken, per Section 41-4707(1)(b), Idaho Code, premiums must be refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier shall seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage shall be considered null and void. (1-25-95)()

~~b. Employer Misstatements Rescissions taken against the coverage of an entire small employer (including employees and dependents) shall be limited to circumstances under which the application misstatements have been made by the small employer in his or her capacity as an employer. (1-25-95)~~

(BREAK IN CONTINUITY OF SECTIONS)

055. APPLICATION TO REENTER STATE.

~~01. **Restrictions On Offering Small Group Health Insurance.** A carrier that has been prohibited from writing coverage for small employers in this state pursuant to Section 41-4707(2), Idaho Code, may not resume offering health benefit plans to small employers in this state until the carrier has made a petition to the Director to be reinstated as a small employer carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. (1-25-95)~~

~~02. **Restrictions Based On Geographic Service Area.** In the case of a small employer carrier doing business in only one (1) established geographic service area of the state, if the small employer carrier elects to non renew a health benefit plan under Section 41-4707(1)(f), Idaho Code, the small employer carrier shall be prohibited from offering health benefit plans to small employers in that service area for a period of five (5) years. (1-25-95)~~

(BREAK IN CONTINUITY OF SECTIONS)

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. **Previous Coverage Or Existing Coverage.** In determining whether a health benefit plan or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-4703(19), 41-4703(235), and 41-4708(3)(bc), and 41-4708(3)(c), Idaho Code, a small employer carrier shall interpret the Act no less favorably to an insured individual than the following: (1-25-95)()

a. A health benefit plan, certificate or other health benefit arrangement, with the exception of a policy issued under Title 41, Chapter 52, Idaho Code, shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement; and (1-25-95)()

b. A health benefit plan, certificate or other benefit arrangement shall be considered to provide benefits similar to or exceeding the benefits provided under the basic health benefit plan if the policy, certificate or other benefit arrangement provides benefits that: (1-25-95)

i. Have an actuarial value (as considered for a normal distribution of groups) that is not substantially less than the actuarial value of the basic health benefit plan; or (1-25-95)

ii. Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for such services in the basic health benefit plan. (1-25-95)

c. In making a determination under Subsection 060.01.b., a small employer carrier shall evaluate the previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its decision solely on the fact that one portion of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the basic health benefit plan. (1-25-95)

02. Particular Service. For the purposes of Section 41-4708(3)(~~bc~~), Idaho Code, an individual will be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement covering such individual met the definition of qualifying previous coverage contained in Section 41-4703(2~~35~~), Idaho Code, and provided any benefit with respect to the service. (~~1-25-95~~)()

03. Source Of Previous Or Existing Coverage. A small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage. (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

067. RESTRICTIVE RIDERS.

~~**01. Restrictive Riders.** A restrictive rider, endorsement or other provision that would violate the provisions of Section 41-4708(3)(c)(ii), Idaho Code, and that was in force on the effective date of this rule may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this rule. A small employer carrier shall provide written notice to those small employers whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan. (1-25-95)~~

~~**02. Basic, Standard, And Catastrophic Plans.** Except as permitted in Section 41-4708(3), Idaho Code, a small employer carrier shall not modify or restrict a basic, standard, or catastrophic health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan. (7-1-98)~~

~~**03. Other Health Benefit Plans.** Except as permitted in Section 41-4708(3), Idaho Code, a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions, including but not limited to pregnancy, or services otherwise covered by the plan. (1-25-95)()~~

(BREAK IN CONTINUITY OF SECTIONS)

075. RULES RELATED TO FAIR MARKETING.

01. Small Employer Carrier Shall Actively Market. A small employer carrier shall actively market each of its health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of health benefit plans including but not limited to the basic, standard, or catastrophic health

benefit plans unless the carrier has good cause and has received the prior approval of the Director. (7-1-98)()

~~**02. Marketing Basic, Standard, Or Catastrophic Plans.** In marketing the basic, standard, or catastrophic health benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state shall also be authorized to market the basic, standard, or catastrophic health benefit plans. (7-1-98)~~

~~**03. Offer Must Be In Writing.** A small employer carrier shall offer at least the basic, standard, or catastrophic health benefit plans to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer shall be in writing and shall include at least the following information: (7-1-98)~~

~~a. A general description of the benefits contained in the basic, standard, or catastrophic health benefit plans and any other health benefit plan being offered to the small employer, and (7-1-98)~~

~~b. Information describing how the small employer may enroll in the plans. The offer may be provided directly to the small employer or delivered through a producer. (1-25-95)~~

~~**042. Timeliness Of Price Quote.** A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote. (1-25-95)~~

~~**05. Restrictions As To Application Process.** A small employer carrier may not apply more stringent or detailed requirements related to the application process for the basic, standard, or catastrophic health benefit plans than are applied for other health benefit plans offered by the carrier. (7-1-98)~~

~~**06. Denial Of Coverage.** If a small employer carrier denies coverage under a health benefit plan to a small employer on the basis of a risk characteristic, the denial shall be in writing and shall be maintained in the small employer carrier's office. This written denial shall state with specificity the risk characteristic(s) of the small employer group that made it ineligible for the health benefit plan it requested (for example, health status, industry, group size, etc.). The denial shall be accompanied by a written explanation of the availability of the basic, standard, or catastrophic health benefit plans from the small employer carrier. The explanation shall include at least the following: (7-1-98)~~

~~a. A general description of the benefits contained in each such plan; (1-25-95)~~

~~b. A price quote for each such plan; and (1-25-95)~~

~~e. Information describing how the small employer may enroll in such plans. The written information described in this paragraph may be provided within the time periods provided in Subsection 075.04 directly to the small employer or delivered through an authorized producer. (1-25-95)~~

~~**07. Lowest Priced Basic, Standard, Or Catastrophic Plan.** The price quote required under Subsection 075.06.b. shall be for the lowest priced basic, standard, or catastrophic health benefit plan for which the small employer is eligible. (7-1-98)~~

~~**083. Toll-Free Telephone Service.** A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage. (1-25-95)~~

~~**094. Restrictions As To Contribution To Association.** The small group carrier shall not require a small~~

employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of Section 41-4708(1)(b)(ii), Idaho Code. (1-25-95)

105. No Requirement To Qualify For Other Insurance Product. A small employer carrier may not require, as a condition to the offer of sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service. (1-25-95)

106. Plans Subject To Requirement Of The Act And This Rule. Carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this Rule. Carriers shall elicit the following information from applicants for such plans at the time of application: (1-25-95)()

a. ~~Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and~~ (1-25-95)

b. ~~Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plans as part of plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106, Internal Revenue Code.~~ (1-25-95)

~~**12. Failure To Comply.** If a small employer carrier fails to comply with Subsection 075.11, the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with Subsection 075.11.~~ (1-25-95)

1307. Annual Filing Requirement. A small employer carrier shall file annually the following information with the Director related to health benefit plans issued by the small employer carrier to small employers in this state on forms prescribed by the Director: (1-25-95)

a. The number of small employers that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); (1-25-95)

b. The number of small employers that were covered under the basic, standard, or catastrophic health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). (7-1-98)

c. The number of small employer health benefit plans in force in each county (or by five digit zip code) of the state as of December 31 of the previous calendar year; (1-25-95)

d. The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year; (1-25-95)

e. The number of small employer health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and (1-25-95)

f. The number of health benefit plans that were issued to residents that were uninsured for at least sixty-three (63) days prior to issue. (7-1-98)

1408. Total Number Of Residents. All carriers shall file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under stop loss plans. (1-25-95)

1509. Filing Date. The information described in Subsections 075.1307 and 075.1408 shall be filed no later than March 15, each year. (1-25-95)()

160. Specific Data. For purposes of this section, health benefit plan information shall include policies or certificates of insurance for specific disease, hospital confinement indemnity and stop loss coverages. (1-25-95)

(BREAK IN CONTINUITY OF SECTIONS)

081. STATUS OF CARRIERS AS SMALL EMPLOYER CARRIERS.

01. Market Status. Each carrier providing health benefit plans in this state shall make a filing to the Director if it intends to continue or discontinue to operate as a small employer carrier in this state under the terms of this Rule. (1-25-95)

02. Restrictions As To The Offering Of Insurance. Subject to Subsection 081.03, a carrier shall not offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the filing provided pursuant to Subsection 081.01 indicates that the carrier intends to operate as a small employer carrier in this state. (1-25-95)

03. Specific Compliance Requirements. If the filing made pursuant Subsection 081.01 indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state only if the carrier complies with the following provisions: (1-25-95)

a. The carrier complies with the requirements of the Act (other than Sections 41-4709, 41-4710, and 41-4711, Idaho Code) with respect to each of the health benefit plans previously issued to small employers by the carrier. (1-25-95)

b. The carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by the carrier. The provisions of the Act (other than Sections 41-4709, 41-4710, and 41-4711, Idaho Code) and this Rule shall apply to the coverage issued to such new entrants. (1-25-95)

c. The carrier complies with the requirements of Sections 067 and 091 of this Rule as they apply to small employers whose coverage has been terminated by the carrier and to individuals and small employers whose coverage has been limited or restricted by the carrier. (1-25-95)()

04. Not Eligible For Reinsurance Program. A carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the reinsurance program established under Section 41-4711, Idaho Code. (1-25-95)

05. Precluded From Operating In Idaho. If the filing made pursuant Subsection 081.01 indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state (except as provided for in Subsections 081.03.a. through 081.03.c.) for a period of five (5) years from the date of the filing. Upon a written request from such a carrier, the Director may reduce the period provided for in the previous sentence if the Director finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state. (1-25-95)

~~082. -- 090. (RESERVED).~~

~~091. RESTORATION OF COVERAGE.~~

~~01. Restoration Of Coverage.~~ Except as provided in Subsection 091.02, a small employer carrier shall, as a condition of continuing to transact business in this state with small employers, offer to provide a health benefit plan as described in Subsection 091.04 to any small employer whose coverage was terminated or not renewed by such small employer carrier after July 1, 1993. (1-25-95)

~~02. The Offer.~~ The offer required under Subsection 091.01 shall not be required with respect to a health benefit plan that was not renewed if: (1-25-95)

~~a. The health benefit plans was not renewed for reasons permitted in Section 41-4707(1), Idaho Code;~~
~~or-~~ (1-25-95)

~~b. The non renewal was a result of the small employer voluntarily electing coverage under a different health benefit plan.~~ (1-25-95)

~~**03. Time Limit.** The offer made under Subsection 091.01 and 091.02 shall occur not later than thirty (30) days after a carrier indicates its intention to operate as a small employer carrier in this state pursuant to Section 081. A small employer shall be given at least sixty (60) days to accept an offer made pursuant to Subsections 091.01 and 091.02.~~ (1-25-95)

~~**04. Health Benefit Plan Requirement.** A health benefit plan provided to a terminated small employer pursuant to Subsection 091.01 shall meet the following conditions:~~ (1-25-95)

~~a. The health benefit plan shall contain benefits that are identical to the benefits in the health benefit plan that was terminated or non renewed;~~ (1-25-95)

~~b. The health benefit plan shall not be subject to any waiting periods (including exclusion periods for pre-existing conditions) or other limitations on coverage that exceed those contained in the health benefit plan that was terminated or non renewed. In applying such exclusions or limitations, the health benefit plan shall be treated as if it were continuously in force from the date it was originally issued to the date that it is restored;~~ (1-25-95)

~~e. The health benefit plan shall not be subject to any provision that restricts or excludes coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan;~~ (1-25-95)

~~d. The health benefit plan shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier shall offer coverage to each dependent of such eligible employees;~~ (1-25-95)

~~e. The premium rate for the health benefit plan shall be no more than the premium rate charged to the small employer on the date the health benefit plan was terminated or non renewed; provided that, if the number or case characteristics of the eligible employees (or their dependents) of the small employer has changed between the date the health benefit plan was terminated or non renewed and the date that it is restored, the carrier may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may further be adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health benefit plan may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date of health benefit plan is restored. Any such increase shall be subject to the provisions of Section 41-4706, Idaho Code; and~~ (1-25-95)

~~f. The health benefit plan shall not be eligible to be reinsured under the provisions of Section 41-4711, Idaho Code, except that the carrier may reinsure new entrants to the health benefit plan who enroll after the restoration of coverage.~~ (1-25-95)

0982. -- 999. (RESERVED).

IDAPA 18 - DEPARTMENT OF INSURANCE
18.01.70 - RULE TO IMPLEMENT THE SMALL EMPLOYER HEALTH
INSURANCE AVAILABILITY ACT PLAN DESIGN

DOCKET NO. 18-0170-9901

NOTICE OF TEMPORARY RULE

EFFECTIVE DATE: The effective date for this temporary rule is March 15, 1999.

AUTHORITY: In compliance with Section 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule. This action is authorized pursuant to Sections 41-211 and 41-4715, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

On March 15, 1999, the Idaho Supreme Court ruled that the cap on reimbursement for chiropractic services contained in the current rule violates the equal protection clauses of the state and federal constitutions. The proposed amendment removes the cap on chiropractic services and imposes a cap on reimbursement for certain types of medical services regardless of who provides the services.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this temporary rule, contact Joan Krosch, Health Insurance Coordinator for the Department of Insurance, at (208) 334-4250.

Dated this 14th day of June, 1999.

Mary L. Hartung, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THE FOLLOWING IS TEXT OF DOCKET NO. 18-0170-9901

016. LIMITATIONS AND EXCLUSIONS.

01. Services Not Medically Necessary. Excluded. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (1-25-95)

02. No Coverage. Custodial, convalescent or intermediate level care or rest cures. (1-25-95)

03. Experimental Or Investigational. Services which are experimental or investigational. (1-25-95)

04. Workers' Compensation, Medicare, CHAMPUS. Services eligible for coverage by Workers'

Compensation, Medicare or CHAMPUS. (1-25-95)

05. No Charges. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. (1-25-95)

06. No Medical Diagnosis. Services for weight control, nutrition, and smoking cessation, including self-help and training programs as well as prescription drugs, used in conjunction with such programs and services. (7-1-98)

07. Cosmetic Surgery. Cosmetic surgery and services, except for treatment for non-congenital injury or surgery. Mastectomy reconstruction is covered if within two (2) years of mastectomy. (1-25-95)

08. Artificial Insemination, Infertility, Sexual Dysfunction. Artificial insemination and infertility treatment. Treatment of sexual dysfunction not related to organic disease. (1-25-95)

09. Induced Infertility. Services for reversal of elective, surgically or pharmaceutically induced infertility. (1-25-95)

10. Vision. Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. Vision tests and glasses will be covered for children under the age of twelve (12), except in catastrophic health benefit plans. (7-1-98)

11. Limitation Foot Care. For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (7-1-98)

12. ~~Spinal Manipulation.~~ Chiropractic services Manipulative Therapy And Related Treatment. Manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities will be subject to one thousand dollars (\$1,000) per year limit, subject to the policy deductible, and co-insurance, or co-payment. ~~(6-30-95)~~(3-15-99)T

13. Dental, Orthodontic Services. (7-1-98)

a. For Basic and Standard plans: Dental and orthodontic services, except those needed for treatment of a medical condition or injury or as specifically allowed in the policy for children under the age of twelve (12). (7-1-98)

b. For Catastrophic plans: Dental care or treatment, except for injury sustained while insured under this policy, or as a result of nondental disease covered by the policy. (7-1-98)

14. Hearing Tests. Hearing tests without illness being suspect. (1-25-95)

15. Hearing Aids, Supplies. Hearing aids and supplies, tinnitus maskers, cochlear implants and exams for the prescription or fitting of hearing aids. (1-25-95)

16. Speech Tests. Speech tests and therapy except as specifically allowed in the policy for children under the age of twelve (12). (1-25-95)

17. Private Room Accommodation Charges. Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (1-25-95)

18. Services Performed By A Member Of The Insureds Family. Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. (1-25-95)

19. No Coverage Prior To Effective Date Of Coverage. Care incurred before the effective date of the

- person's coverage. (1-25-95)
- 20. Covered Injury Or Disease.** Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. (1-25-95)
- 21. Act Of War Or Armed Conflict.** Injury or sickness caused by war or armed international conflict. (1-25-95)
- 22. Operation And Treatment, Sexual Change.** Sex change operations and treatment in connection with transsexualism. (1-25-95)
- 23. Counseling.** Marriage and family and child counseling except as specifically allowed in the policy. (1-25-95)
- 24. Acupuncture.** (7-1-98)
- a. For Basic and Standard plans: Acupuncture except when used as anesthesia during a covered surgical procedure. (7-1-98)
- b. For Catastrophic plans: Acupuncture. (7-1-98)
- 25. Private Duty Nursing.** Private duty nursing except as specifically allowed in the policy. (1-25-95)
- 26. Employer Maintained Medical Or Dental Care.** Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. (1-25-95)
- 27. Termination.** Services incurred after the date of termination of a covered person's coverage except as allowed by the extension of benefits provision of the policy, if any. (7-1-98)
- 28. Personal Convenience Items.** Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (1-25-95)
- 29. Failure To Keep A Scheduled Visit.** Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. (1-25-95)
- 30. Screening Examinations.** Charges for screening examinations except as otherwise provided in the policy. (1-25-95)
- 31. No Allowance.** Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness. (1-25-95)
- 32. Preexisting Conditions.** Pre-existing conditions, except as provided specifically in the policy. (1-25-95)

IDAPA 18 - IDAHO DEPARTMENT OF INSURANCE
18.01.73 – RULE TO IMPLEMENT THE INDIVIDUAL HEALTH INSURANCE
AVAILABILITY ACT PLAN DESIGN

DOCKET NO. 18-0173-9901

NOTICE OF TEMPORARY RULE

EFFECTIVE DATE: The effective date for this temporary rule is March 15, 1999.

AUTHORITY: In compliance with Section 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule. This action is authorized pursuant to Sections 41-211 and 41-5211, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

On March 15, 1999, the Idaho Supreme Court ruled that the cap on reimbursement for chiropractic services contained in the current rule violates the equal protection clauses of the state and federal constitutions. The proposed amendment removes the cap on chiropractic services and imposes a cap on reimbursement for certain types of medical services regardless of who provides the services.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this temporary rule, contact Joan Krosch, Health Insurance Coordinator for the Department of Insurance, at (208) 334-4250.

Dated this 14th day of June, 1999.

Mary L. Hartung, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THE FOLLOWING IS TEXT OF DOCKET NO. 18-0173-9901

011. LIMITATIONS AND EXCLUSIONS.

01. Not Medically Necessary. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (6-30-95)

02. Custodial, Convalescent, Intermediate. Custodial, convalescent or intermediate level care or rest cures. (6-30-95)

03. Experimental, Investigational. Services which are experimental or investigational. (6-30-95)

- 04. Workers Compensation, Medicare Or CHAMPUS.** Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS. (6-30-95)
- 05. No Charges, No Legal Obligation To Pay.** Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. (6-30-95)
- 06. No Medical Diagnosis.** Services for weight control, nutrition, and smoking cessation, including self-help and training programs, as well as prescription drugs used in conjunction with such programs and services. (7-1-98)
- 07. Cosmetic Surgery.** Cosmetic surgery and services, except for treatment for non-congenital injury or surgery. Mastectomy reconstruction is covered if within two (2) years of mastectomy. (6-30-95)
- 08. Artificial Insemination And Infertility Treatment.** Artificial insemination and infertility treatment. Treatment of sexual dysfunction not related to organic disease. (6-30-95)
- 09. Reversal Of Elective Infertility.** Services for reversal of elective, surgically or pharmaceutical induced infertility. (6-30-95)
- 10. Vision Therapy.** Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. (6-30-95)
- 11. Weak, Strained, Or Flat Feet.** For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (6-30-95)
- 12. ~~Spinal Manipulation.~~ Chiropractic services Manipulative Therapy And Related Treatment. Manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities will be subject to one thousand dollars (\$1,000) per year limit, subject to the policy deductible, and co-insurance, or co-payment. (~~6-30-95~~)(3-15-99)T**
- 13. Dental And Orthodontic Services.** (7-1-98)
- a. For Basic and Standard plans: Dental and orthodontic services, except those needed for treatment of a medical condition or injury or as specifically allowed in the policy for children under the age of twelve (12). (7-1-98)
- b. For Catastrophic plans: Dental care or treatment, except for injury sustained while insured under this policy, or as a result of nondental disease covered by the policy. (7-1-98)
- 14. Hearing Tests.** Hearing tests without illness being suspect. (6-30-95)
- 15. Hearing Aids.** Hearing aids and supplies, tinnitus maskers, cochlear implants and exams for the prescription or fitting of hearing aids. (6-30-95)
- 16. Excludes.** Speech tests and therapy. (6-30-95)
- 17. Private Room.** Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (6-30-95)
- 18. Services Performed By A Member Of Family.** Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. (6-30-95)
- 19. Prior To Effective Date.** Care incurred before the effective date of the person's coverage.

- (6-30-95)
- 20. Immunizations And Medical Exams And Tests.** Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. (6-30-95)
- 21. Injury Or Sickness.** Injury or sickness caused by war or armed international conflict. (6-30-95)
- 22. Sex Change Operations.** Sex change operations and treatment in connection with transsexualism. (6-30-95)
- 23. Marriage and Family Counseling.** Marriage and family and child counseling except as specifically allowed in the policy. (6-30-95)
- 24. Acupuncture.** (7-1-98)
- a. For Basic and standard plans: Acupuncture except when used as anesthesia during a covered surgical procedure. (7-1-98)
- b. For Catastrophic plans: Acupuncture. (7-1-98)
- 25. Private Duty Nursing.** Private duty nursing except as specifically allowed in the policy. (6-30-95)
- 26. Medical Services Received From Employer, Labor Union Association.** Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. (6-30-95)
- 27. Termination.** Services incurred after the date of termination of a covered person's coverage, except as allowed by extension of benefits provision in the policy, if any. (7-1-98)
- 28. Personal Hygiene And Convenience Items.** Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (6-30-95)
- 29. Failure To Keep A Scheduled Visit.** Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. (6-30-95)
- 30. Screening Examinations.** Charges for screening examinations except as otherwise provided in the policy. (6-30-95)
- 31. Wigs Or Hair Loss.** Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness. (6-30-95)
- 32. Pre-Existing Conditions.** Pre-existing conditions, except as provided specifically in the policy. (6-30-95)

IDAPA 22 - BOARD OF MEDICINE

**22.01.01 - RULES OF THE BOARD OF MEDICINE FOR LICENSURE TO PRACTICE MEDICINE
AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY**

DOCKET NO. 22-0101-9901

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rule-making. The action is authorized pursuant to Section 54-1806(2)(11) and Section 54-1806A, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 1999.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rule-making:

Proposed rules will establish annual continuing medical education (CME) requirements for physicians to increase/maintain current medical education of physicians so that public safety and protection may be enhanced. Rules will require 20 hours of Category I and 30 hours of Category II continuing medical education annually and compliance to requirement will be reported on application for annual license renewal.

FEE SUMMARY: Rule changes do not impose any fee increases.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rule-making was not conducted because the text of the proposed rules will be sent to all currently licensed physicians for comment prior to the final approval of the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Darleene Thorsted at 334-2822.

Anyone may submit written comments regarding this proposed rule-making. All written comments must be directed to the undersigned and must be delivered on or before August 25, 1999.

DATED this 23rd day of June, 1999.

Darleene Thorsted
Executive Director
Idaho State Board of Medicine
280 North 8th Street
PO Box 83720
Boise, ID 83720-0058
Phone: (208) 334-2822 Fax: 208-334-2801

THE FOLLOWING IS TEXT OF DOCKET NO. 22-0101-9901

080. --099: (RESERVED) CONTINUING MEDICAL EDUCATION.

01. Active License Holders. Every year, each person holding an active license to practice medicine in this State shall complete fifty (50) credit hours of continuing medical education (CME), twenty (20) hours of which shall be in Category 1. ()

02. Physicians Exempt From CME Requirements. The following physicians shall be exempt from these CME requirements: ()

a. Physicians who are initially licensed by the Board and who have not renewed their licenses for the first time. ()

b. Physicians who hold an inactive license, and retired physicians who hold an active license; however, physicians who have had their license suspended or in some other way restricted by the Board shall meet the requirements unless otherwise stipulated by Board order. ()

c. Physicians specifically exempted from this requirement by the Board due to cases of hardship, disability, illness, military service or other circumstances as the Board deems appropriate if supported by adequate documentation submitted to and acceptable to the Board. ()

03. Category 1. All Category 1 programs will be identified as such by the approved sponsoring or co-sponsoring organization. ()

04. Category 2. Category 2 activities include CME programs with non-accredited sponsorship, medical teaching, papers, publications, books, presentations or exhibits, non-supervised individual CME activities, staff meetings and other meritorious learning experiences. ()

05. Credit Hours Allowed For Each Clock Hour. One (1) hour of credit will be allowed for each clock hour of participation in approved continuing medical education activities. ()

06. Approved Continuing Medical Education Activities. Approved continuing medical education activities include the following: ()

a. Internship, residency or fellowship in a teaching institution approved by the American Medical Association or the Association of American Medical Colleges or the American Osteopathic Association. ()

i. One (1) credit hour may be claimed for each full day of training. ()

ii. No other credit may be claimed during the time a physician is in full-time training in an accredited program. ()

iii. Less than full-time study may be claimed on a pro-rata basis. ()

b. Education for an advanced degree in a medical or medically related field in a teaching institution approved by the American Medical Association or the Association of American Medical Colleges or the American Osteopathic Association. ()

i. One (1) credit hour may be claimed for each full day of training. ()

ii. Less than full time study may be claimed on a pro-rata basis. ()

c. Full-time research in a teaching institution approved by the American Medical Association or the Association of American Medical Colleges or the American Osteopathic Association. ()

i. One (1) credit hour may be claimed for each full day of research. ()

- ii. Less than full-time study may be claimed on a pro-rata basis. ()
 - d. Education certified as Category 1 by an organization accredited by the Accreditation Council on Continuing Medical Education such as, but not limited to: ()
 - i. AMA (American Medical Association) Category 1 credit: ()
 - ii. AOA (American Osteopathic Association) Category 1 credit. ()
 - iii. AAFP (American Academy of Family Physicians) Prescribed credit: ()
 - iv. ACOG (American College of Obstetricians and Gynecologists) Cognates, Category 1: ()
 - v. ACEP (American College of Emergency Physicians) Category 1. ()
 - e. Medical educational programs designed to provide necessary understanding of current developments, skills, procedures or treatments related to the practice of medicine, provided by organizations or institutions that have not been accredited by the Accreditation Council on Continuing Medical Education. ()
 - f. Serving as an instructor for medical students, house staff, other physicians or allied health professionals from a hospital or institution with a formal training program, where the instruction activities are such as will provide the licensee with the necessary understanding of current developments, skills, procedures or treatments related to the practice of medicine. ()
 - g. Publication or presentation of a medical paper, report, book, that is authored and published and deals with the current developments, skills, procedures, or treatments related to the practice of medicine. ()
 - i. Credits may be claimed only once for materials presented and credits may be claimed for the date of publication or presentation. ()
 - ii. One (1) credit hour may be reported per hour of preparation, writing and/or presentation. ()
 - h. Credit hours may be earned for any of the following activities which provide the necessary understanding of current developments, skills, procedures or treatments related to the practice of medicine: ()
 - i. Completion of a medical education program based on self-instruction which utilized videotapes, audiotapes, films, filmstrips, slides, radio broadcasts, and computers; ()
 - ii. Independent reading of scientific journals and books; ()
 - iii. Preparation for specialty Board certification or recertification examinations; ()
 - iv. Participation on a staff committee or quality of care or utilization review in a hospital or institution or government agency. ()
- 07. Licensee Responsibility.** It is the responsibility of the licensee to verify approval with the source of the program, not with the Board, and licensee should verify approval before taking the course. ()
- 08. Certify Continuing Medical Education Requirements With Application For Renewal.** Each year, with the application for renewal of an active license to practice medicine in this State, the Board will include a form which requires the person holding the license to certify by signature, under penalty of perjury, that he or she has met the continuing medical education requirements. ()
- a. In addition, the Board may randomly require physicians submitting such a certification to demonstrate, prior to renewal of license, documentation of the continuing medical education requirements stated in his or her certification. ()

09. Record Of Attendance. Each licensed physician who must meet these requirements shall maintain a record of attendance and the supporting documents for continuing medical education for a period of three (3) years from the date of attendance or participation. ()

a. At a minimum, the following must be documented and recorded: ()

i. Name of provider: ()

ii. Name of program: ()

iii. Hours of continuing education Units completed: ()

iv. Date of completion: ()

v. Evidence of AMA Category 1 credit or AOA Category 1 credit or other documentation to support the number of credits completed or earned. ()

10. Continuing Medical Education Credits. Continuing medical education credits may not be carried over from one (1) reporting period to another and must be completed or earned within the reporting period as specified on the annual renewal form. ()

11. Failure To Comply With Continuing Medical Education Requirements. Failure to comply with the continuing medical education requirement or making false statements or misrepresentations on the renewal form will be grounds for discipline under Section 54-1814(2), Idaho Code. ()

081. -- 099. (RESERVED).

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.19.01 - RULES OF THE BOARD OF RESIDENTIAL CARE FACILITY ADMINISTRATORS
DOCKET NO. 24-1901-9901

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 27, 1999.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-4205, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 1999.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking: Establish that the examination will be administered on the second Tuesday in January, April, July and October of each year.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: Confer a benefit to applicants by providing an additional two times per year when the examination will be available.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Dee Ann Randall, (208) 334-3233.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 25, 1999.

DATED this 4th day of June, 1999.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS TEXT OF DOCKET NO. 24-1901-9901

300. EXAMINATIONS (Rule 300).

01. Application And Deadline Date For Filing. An application for examination must be accompanied by the examination fee and proof of completion of approved curriculum. Applications must be received at least thirty (30) days prior to the date of examination. (7-1-98)

02. Individuals Who Have Special Needs. Individuals who have special needs as defined by the

American Disabilities Act must specify those needs or required services as indicated on the application form.

(7-1-93)

03. Dates Of Exams. Examinations will be administered ~~semi-annually~~ on the second Tuesday in ~~January, April, July,~~ and October of each year at times and locations to be set by the board. ~~(7-1-98)~~(4-27-99)T

04. Contents Of Exam. The examination will consist of two (2) sections. (7-1-93)

a. Section One will include questions from all or some of the following topics: (7-1-98)

i. Business Planning and Marketing. (7-1-93)

ii. Fiscal Planning and Management. (7-1-93)

iii. Human Resource Planning. (7-1-93)

iv. Residential Health Services. (7-1-93)

v. Nutrition and Food Service. (7-1-93)

vi. Working with the Elderly. (7-1-93)

vii. Working with the Mentally Ill. (7-1-93)

viii. Social and Recreational Activities. (7-1-93)

ix. Legal Issues. (7-1-93)

x. Licensing Process. (7-1-93)

xi. Housekeeping. (7-1-93)

xii. Physical Maintenance and Fire Safety. (7-1-93)

xiii. Developmentally Disabled. (7-1-98)

b. Section Two will include questions from the Idaho Board and Care Act, Chapter 33, Title 39, Idaho Code and the Idaho Department of Health and Welfare rules promulgated thereunder and appearing at Title 3, Chapter 21. (7-1-93)

05. Passing Score On Exam. An examination is passed by obtaining a score of seventy percent (70%) or better on each section. Applicants who fail to pass one (1) section of the examination must retake and pass that section within two (2) years from the date of the first examination or the application file will be terminated without further notice to the applicant, and the applicant will be required to begin the process as a new applicant except that no further temporary permits will be granted. (7-1-98)

06. Requirements For Retakes. There will be a seventy-five dollar (\$75) fee for retakes of any or all portions of the examination. Individuals desiring to be reexamined must file a letter of intent, together with the appropriate fee, with the board. The letter and fee must be received by the Bureau at least thirty (30) days prior to examination. (7-1-93)

IDAPA 31 - PUBLIC UTILITIES COMMISSION

31.71.01 - RAILROAD CLEARANCE RULES

DOCKET NO. 31-7101-9901

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given of the Idaho Public Utilities Commission's proposed rulemaking. This action is authorized pursuant to Section 67-5230, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be scheduled only if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, no later than August 18, 1999.

The hearing site will be accessible to persons with disabilities. Request for accommodations must be made no later than five (5) days prior to the hearing, to the Commission's address set out below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rules:

To lower the minimum vertical clearance required over railroad tracks from 23 feet 6 inches (23' 6") to "the vertical clearance required by the owner of the railroad tracks or 22 feet 6 inches (22' 6"), whichever is greater".

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01, informal negotiated rulemaking was conducted.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rules, contact Weldon B. Stutzman, Deputy Attorney General at (208) 334-0318.

DEADLINE FOR WRITTEN COMMENTS: Anyone may submit written comments regarding these proposed rules. All written comments and data concerning the proposed rules must be delivered to the Commission Secretary at the address identified above or must be postmarked on or before August 25, 1999. Persons desiring to comment are encouraged to submit written comments at their earliest convenience rather than wait until the comment deadline.

DATED this 22nd day of June 1999.

Myrna J. Walters
Commission Secretary
Idaho Public Utilities Commission
PO Box 83720
Boise, ID 83702-5983
Telephone: (208) 334-0338
FAX: (208) 334-3762

Street Address for Express Mail:
472 West Washington Street
Boise, ID 83720-0074

THE FOLLOWING IS TEXT OF DOCKET NO. 31-7101-9901

201. OVERHEAD CLEARANCE IN GENERAL (Rule 201).

The allowable clearances are:

(7-1-93)

01. Begun, Installed Or Constructed After April 1, 1955. For structures, operating appurtenances, pole lines, service facilities and track arrangements begun, installed or constructed after April 1, 1955, and before September 1, 1980 twenty-two feet six inches (22'6"). (7-1-93)

02. Begun, Installed Or Constructed After September 1, 1980. For structures, operating appurtenances, pole lines, service facilities and track arrangements begun, installed or constructed after September 1, 1980, the vertical clearance required by the owner of the railroad tracks or twenty-three two feet six inches (23²'6"), whichever is greater. (7-1-93)()

03. Structures On Main Lines. For structures on main lines identified by railroad for possible electrification: (7-1-93)

a. At twenty-five (25) kilovolts twenty-four feet three inches (24'3"); or (7-1-93)

b. At fifty (50) kilovolts twenty-six (26') feet. (7-1-93)

IDAPA 35 - STATE TAX COMMISSION
35.01.02 - IDAHO SALES AND USE TAX ADMINISTRATIVE RULES
DOCKET NO. 35-0102-9901
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: This temporary rule is effective July 1, 1999.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rule-making procedures have been initiated. The action is authorized pursuant to Section(s) 63-105A and 63-3624, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 1999.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule-making:

Sales Tax Rule 130. This rule is being promulgated to clarify procedures for Section 63-3620C, Idaho Code, which was enacted by 1999 legislation. Promoters of certain types of events are required to check for Seller's Permits for participating vendors and to issue temporary permits when necessary. This law becomes effective July 1, 1999.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Statutory timing of the program requires the rule be adopted as a temporary rule.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

Not Applicable.

NEGOTIATED RULE-MAKING: Pursuant to IDAPA 04.11.01.811, negotiated rule-making was not conducted.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Jim Husted, at (208) 334-7530.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 25, 1999.

DATED this 23rd day of June, 1999.

Jim Husted, Tax Policy Specialist
State Tax Commission
800 Park, Plaza IV, P.O. Box 36
Boise, ID 83722
(208) 334-7530
FAX (208) 334-7844

THE FOLLOWING IS TEXT OF DOCKET NO. 35-0102-9901

128. - ~~99~~129. (RESERVED).

130. PROMOTER SPONSORED EVENTS (Rule 130).

Promoters at promoter sponsored events, as defined in Section 63-3620C, Idaho Code, shall within ten (10) days following the beginning of the event, forward to the State Tax Commission a completed Form ST-124 for each exhibitor participating in the event. This form shall include: ()

01. Promoter Information. The name of the promoter sponsoring the event, the name of the event, the event location, and the dates of the event. ()

02. Exhibitors Participating In Event. The names, addresses, and phone numbers of the exhibitors participating in the event. ()

03. Identification Number. Either the exhibitor's federal employer identification number or social security number. ()

04. Seller's Permit Number. The exhibitor's seller's permit number or a statement that the exhibitor is not making taxable sales. ()

05. Copy Of Temporary Seller's Permit. Copies of temporary seller's permits assigned by the promoter, if any. ()

06. Other Information. Other information may be required if deemed necessary by the State Tax Commission. ()

131. - 999. (RESERVED).

IDAPA 35 - STATE TAX COMMISSION
35.01.04 - IDAHO ESTATE AND TRANSFER TAX ADMINISTRATIVE RULES
DOCKET NO. 35-0104-9901
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rule-making. The action is authorized pursuant to Section(s) 63-105, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 1999.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rule-making:

Estate and Transfer Rule 015 is being amended to update provisions on electronic funds transfer pursuant to Section 67-2026 and 67-2026A, Idaho Code. Appendix A and B attached and referred to in these rules are no longer necessary and are being deleted.

Estate and Transfer Rule 017 is being amended to refer to the State Tax Commission's Administrative and Enforcement Rules for the current rate of interest on refunds as provided in Section 63-3045, Idaho Code.

Estate and Transfer Rule 019 is being amended to update the reference to the State Tax Commission's Administration and Enforcement Administrative Rules.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

No fees applicable.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the proposed change is of a simple nature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact James Husted, at (208) 334-7530.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 25, 1999.

DATED this 23rd day of June, 1999.

James Husted, Tax Policy Specialist
State Tax Commission
800 Park Blvd. Plaza IV
P. O. Box 36
Boise, ID 83722
Phone: (208) 334-7530
FAX: (208) 334-7844

THE FOLLOWING IS TEXT OF DOCKET NO. 35-0104-9901

015. DATE PAYMENT DUE--DATE DEEMED RECEIVED--INTEREST--ELECTRONIC TRANSFER OF FUNDS (Rule 015).

01. Estimated Final Credit. An estate which has an approved time payment for federal estate taxes shall be required to remit only the estimated final amount of federal credit that will be available after taking into consideration the interest deductions that will be allowed as administrative expenses during the extended payment schedule. The Commission may adjust the estimated final credit amount and bill or refund an amount to the estate at the time of remittance. (7-1-93)

a. Upon final payment to the Internal Revenue Service and the final adjustment to the federal credit, settlement will be made with the Commission which may be payment or refund with applicable interest. (7-1-93)

b. It is recognized that no one will be able to exactly estimate the final federal credit prior to the extended payments due to the variable interest rate the Internal Revenue Service uses. Therefore; there shall be no penalties imposed if a good faith estimate ultimately is found to be an underpayment, though statutory interest will be assessed. (7-1-93)

02. Extended Payment. Extended payment of the state tax will only be approved for good cause such as, the need of a sacrifice sale of assets. The number of years for extended payment will be determined by the Commission on an individual basis, but in no case be longer than fourteen (14) years from the date the tax was due. (7-1-93)

a. Any agreement for extended payment is conditional until such time as the estate enters into a written contractual agreement with the Commission, wherein the distributee agrees to: terms of payment including total period of extension, periodic payments, and interest thereon; waiver of all statutes of limitations for the assessment or collection of the estate tax until such tax is paid in full; that unpaid estate taxes including interest shall remain a lien upon the property passed or transferred until all taxes and interest owing are paid in full and; provisions in case of default by the distributee. (7-1-93)

b. The Commission may file a lien in the real property records of the county wherein the property is located and such other places as may be necessary to protect the Commission's interest. (7-1-93)

03. Loss Of Valuation. A credit that is increased due to an increase in federal taxable estate caused by the loss of special use valuation is payable within six (6) months of the date the property ceased to qualify for the special use valuation. (7-1-93)

04. Interest. Interest will accrue on tax beginning six (6) months after the date of disposition or date qualified use ceased. (7-1-93)

05. Electronic Funds Transfer. All taxes due the state must be paid by electronic funds transfer whenever the amount due is one hundred thousand dollars (\$100,000) or greater, in accordance with ~~rules promulgated by the Idaho State Board of Examiners, a copy of which is appended to these rules Sections 67-2026 and 67-2026A, Idaho Code.~~ Sections 67-2026 and 67-2026A, Idaho Code. (7-1-93)()

(BREAK IN CONTINUITY OF SECTIONS)

017. REFUND FOR OVERPAYMENTS (Rule 017).

~~Interest on refunds accrues at the annual rate of twelve percent (12%) simple interest from the day the tax was paid to the Commission to the day the refund is paid. As of January 1, 1994, the rate of interest on refunds is determined~~

annually as provided in Section 63-3045, Idaho Code and Idaho Tax Commission Administration and Enforcement Rule 310. Simple interest shall accrue from the day the tax was paid to the Commission to the day the refund is paid.
(7-1-93)(____)

(BREAK IN CONTINUITY OF SECTIONS)

019. REFERENCE TO RELEVANT INCOME TAX AND ADMINISTRATION AND ENFORCEMENT RULES (Rule 019).

01. Income Tax And Administration And Enforcement Rules. All Income Tax and Administration and Enforcement Rules promulgated by the Commission for collection, enforcement, and administration of the code sections incorporated by reference in Section 14-412, Idaho Code, apply to the administration and enforcement of the estate and transfer tax.
(7-1-93)(____)

02. References. References to income tax in the Income Tax and Administration and Enforcement Rules referred to in this rule shall be described as references to estate and transfer tax for purposes of these rules.
(7-1-93)(____)

APPENDIX A
ELECTRONIC FUNDS TRANSFER

~~REGULATION 21.A.18. Requirements for Electronic Funds Transfer of Tax Payments. [Effective 8/29/88]~~

~~Electronic Fund Transfer (EFT) means any transfer of funds, other than a transaction originated by check, draft or similar paper instrument, which is initiated through an electronic terminal, telephonic instrument, or computer or magnetic tape so as to order, instruct or authorize a financial institution to debit or credit an account.~~

~~All tax payments due the state must be paid by electronic funds transfer whenever the amount is one hundred thousand dollars (\$100,000) or greater. If the due date falls on Saturday, Sunday, or legal holiday, the payment by electronic funds transfer may be made on the first business day thereafter.~~

~~The method of payment does not change any current filing requirements of the written tax forms. If the electronic funds transfer is not made and the written tax return is not filed by the tax due date, the appropriate late filing penalties and interest will apply.~~

~~The electronic funds transfer must be initiated in a timely fashion to ensure receipt of the payment in good, collected funds by the state treasurer's account by the due date.~~

~~REGULATION 21.A.19. Information Required When Making Electronic Funds Transfers. [Effective 8/13/90]~~

~~In order to initiate an EFT payment, the following information is required:~~

- ~~a. Taxpayer's name~~
- ~~b. Taxpayer's identification number (see attached Table 1)~~
- ~~e. Tax type identification number (see attached Table 1)~~
- ~~d. Amount of payment due~~
- ~~e. Due date~~
- ~~f. Name and account of correspondent bank~~

- g. Name of receiving bank (contact the Treasurer's Office for a current list of banks)
- h. Account number of treasurer's account at that bank (contact the Treasurer's Office for current account numbers)
- i. American Bank Association 9 digit number of receiving bank (contact the Treasurer's Office for current numbers)

The name of the receiving bank and EFT verification number must be included with the written tax return.

APPENDIX B
TABLE 1

TAX TYPE NAME	TAX TYPE CODE	TAXPAYER IDENTIFICATION NUMBER
Beer Tax	06316	Permit No. (9 digits)
Cigarette Tax	07215	Permit No. (9 digits)
Corporate Income Tax	02005	Employer ID. No. (EIN) (9 digits)
Estate Tax	20310	Permit Number (9 digits)
Greater Boise Auditorium Dist Hotel/Motel Tax	04812	Permit No. (9 digits)
HFTA	05931	Permit No. (9 digits)
Individual Income Tax	01001	Social Security No. (SSN) (9 digits)
Insurance Premium Tax	07170	Certificate of Authority (4 digits)
Kilowatt Hour Tax	20219	Employer ID. No. (EIN) (9 digits)
Mileage Tax (Ton Mile)	20180	Account No. (6 digits)
Mine License Tax	10318	EIN/SSN (9 digits)
Motor Fuels Tax Gasoline (Includes aviation and gasohol)	05023	License No. (9 digits)
Motor Fuels Tax Special Fuels Tax	05222	EIN/SSN (9 digits)
Motor Fuels Tax Motor Carrier	05327	Permit No. (9 digits)
Sales and Use Tax	04008	Permit No. (9 digits)
Tobacco Tax	07313	Permit No. (9 digits)
Travel and Convention Tax	07411	Permit No. (9 digits)
Unemployment Insurance Tax	13090	Employer Account No. (10 digits)
Wine Tax	06217	Permit No. (6 digits)
Withholding Tax	01109	Permit No. (9 digits)

IDAPA 35 - STATE TAX COMMISSION
35.01.10 - IDAHO CIGARETTE AND TOBACCO PRODUCTS TAX ADMINISTRATIVE RULES
DOCKET NO. 35-0110-9901
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rule-making. The action is authorized pursuant to Section(s) 63-105, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 1999.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rule-making:

Cigarette and Tobacco Tax Rule 018 is being amended to implement the requirement in Section 39-7808(j), Idaho Code, that the State Tax Commission ascertain the amount of tax paid on cigarettes manufactured by manufacturers who are not participants in the "Master Settlement Agreement" settling litigation between several states, including Idaho, and cigarette manufacturers.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the proposed change is of a simple nature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact James Husted at (208) 334-7530.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 25, 1999.

DATED this 23rd day of June, 1999.

James Husted, Tax Policy Specialist
State Tax Commission
800 Park Blvd. Plaza IV
P. O. Box 36
Boise, ID 83722
Phone: (208) 334-7530
FAX: (208) 334-7844

THE FOLLOWING IS TEXT OF DOCKET NO. 35-0110-9901

018. CIGARETTE TAX RETURN (Rule 018).

01. Cigarette Tax Return. All cigarette wholesalers required to affix Idaho stamps to cigarettes, or who make sales to U.S, military or Indians on reservations, or who have a stamping warehouse or business located

within this state and sell cigarettes in interstate commerce are required to file an Idaho cigarette tax return. (7-1-93)

02. Filing Returns. The return shall be in a form prescribed by the Commission and shall be filed on a monthly basis. (7-1-93)

03. Due Date. The return will be filed by the wholesaler on or before the twentieth (20th) day of the month immediately following the month to which the return applies. If the twentieth (20th) day falls on a Saturday, Sunday, or legal holiday, the return shall be due on the next following day which is not a Saturday, Sunday, or legal holiday. (7-1-93)

04. Requirements Of A Valid Return. A tax return or other documents required to be filed in accordance with Section 63-2510, Idaho Code, and this rule must meet the conditions prescribed below. Those which fail to meet these requirements are invalid. They may be rejected and returned to the taxpayer to be redone in accordance with these requirements and refiled. A taxpayer who does not file a valid return will be considered to have filed no return. A taxpayer's failure to properly file in a timely manner may cause certain penalties to be imposed by Sections 63-3030A, 63-3046, and 63-3075, Idaho Code, and rules thereunder. (7-1-93)

a. All cigarette tax return forms must be completed and copies of all pertinent supporting schedules or computations must be attached. The results of supporting computations must be carried forward to applicable lines on the cigarette tax return form. (7-1-93)

b. All cigarette tax returns or other documents filed by the taxpayer must include his cigarette wholesaler's permit number and Federal Taxpayer Identification Number in the space provided. (7-1-93)

c. A cigarette return that does not provide sufficient information to compute a tax liability does not constitute a valid cigarette tax return. (7-1-93)

d. Perfect accuracy is not a requirement of a valid return, even though each of the following conditions is required: it must be on the proper form, as prescribed by the Commission; it must contain a computation of the tax liability and sufficient supporting information to demonstrate how that result was reached; and it must show an honest and genuine effort to satisfy the requirement of the law. (7-1-93)

05. Failure To File A Return. Any wholesaler required to file a return who fails to file such return shall be in violation of this regulation and shall be required to appear before the Commission to show cause as to why his permit should not be revoked. See Section 63-2518, Idaho Code. (7-1-93)

06. Implementation Of Tobacco Master Settlement Agreement. Chapter 78, Title 39, Idaho Code, enacted as part of the settlement agreement with several cigarette manufacturers requires non participating manufacturers to place certain funds in escrow accounts. The State Tax Commission is required to ascertain the amount of state excise tax paid on cigarettes manufactured by manufacturers that are not participating in the Master Settlement Agreement. Therefore, as part of the cigarette tax return, cigarette wholesalers must report separately the number of Idaho cigarette stamps affixed to products manufactured by manufacturers that are not participating in the Master Settlement Agreement. ()

IDAPA 35 - STATE TAX COMMISSION
35.01.11 - IDAHO UNCLAIMED PROPERTY ADMINISTRATIVE RULES
DOCKET NO. 35-0111-9901
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rule-making. The action is authorized pursuant to Section(s) 63-105, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 18, 1999.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rule-making:

Unclaimed Property Rule 019 is being promulgated to require payments of abandoned property over \$100,000 be made by electronic funds transfer pursuant to Sections 67-2026 and 67-2026A, Idaho Code.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the proposed changes are of a simple nature, or required by legislative amendments to the Unclaimed Property Act.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact James Husted, at (208) 334-7530.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 25, 1999.

DATED this 23rd day of June, 1999.

James Husted, Tax Policy Specialist
State Tax Commission
800 Park Blvd. Plaza IV
P. O. Box 36
Boise, ID 83722
(208) 334-7530 FAX (208) 334-7844

THE FOLLOWING IS TEXT OF DOCKET NO. 35-0111-9901

019. PAYMENT OF ABANDONED PROPERTY (Rule 019).

All payments of abandoned property to the administrator must be paid by electronic funds transfer whenever the amount due is one hundred thousand dollars (\$100,000) or greater, in accordance with Sections 67-2026 and 67-2026A, Idaho Code. ()

IDAPA 38 - DEPARTMENT OF ADMINISTRATION
38.05.01 - RULES OF THE DIVISION OF PURCHASING
DOCKET NO. 38-0501-9801
NOTICE OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2000 Idaho State Legislature for final adoption. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 67-2351 et seq., and 67-2356, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the November 4, 1998 Idaho Administrative Bulletin, Volume 98-11, pages 155 through 161.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Joanna L. Guilfooy, Deputy Attorney General, Department of Administration at (208) 332-1832.

DATED this 22nd day of June, 1999.

Joanna L. Guilfooy
Deputy Attorney General
Department of Administration
650 W. State Street, Room 100
P.O. Box 83720
Boise, ID 83720-0003
Ph: (208) 332-1832
Fax: (208) 334-2307

IDAPA 38
TITLE 05
Chapter 01

RULES OF THE DIVISION OF PURCHASING

There are no substantive changes from the proposed rule text.

**The original text was published in the Idaho Administrative Bulletin, Volume 98-11,
November 4, 1998, pages 155 through 161.**

**This rule has been adopted as Final by the Agency and is now pending
review by the 2000 Idaho State Legislature for final adoption.**

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Bulletin Summary of Proposed Rulemaking

PUBLIC NOTICE OF INTENT TO PROPOSE OR PROMULGATE NEW OR CHANGED AGENCY RULES

The following agencies of the state of Idaho have published the complete text and all related, pertinent information concerning their intent to change or make the following rules in the new issue of the state Administrative Bulletin.

IDAPA 07 – DIVISION OF BUILDING SAFETY 277 N. 6th St., Boise, ID 83702

Docket No. **07-0107-9901**, Rules Governing Continuing Education Requirements. Clarifies the continuing education requirements for license renewal of journeymen and master electricians. Comment By: 8/25/99.

Docket No. **07-0311-9901**, Rules Governing Manufactured/Mobile Home Licensing. Rule change adds a financial information disclosure form which must be acknowledged and signed by prospective home buyers at the time the initial purchase order is signed for the sale of a new manufactured home. Comment By: 8/25/99.

IDAPA 08 – BOARD OF EDUCATION/DEPARTMENT OF EDUCATION P.O. Box 83720, Boise, Idaho 83720-0037

Docket No. **08-0203-9902**, Rules Governing Thoroughness. Changes conform to recent changes in federal special education laws and regulations. Comment By: 9/15/99.

IDAPA 11 – DEPARTMENT OF LAW ENFORCEMENT P.O. Box 1177, Meridian, Idaho 83680-1177

Docket No. **11-0201-9801**, Rules of the Idaho State Brand Board. Animal Damage Control increased their fee from 3 to 4 cents per head on all livestock. Comment By: 8/25/99.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE P. O. Box 83720, Boise, ID 83720-0036

Docket No. **16-0101-9901**, Rules for the Control of Air Pollution in Idaho. Changes implement EPA's emission guidelines to control the emissions of HMIWIs and certain municipal solid waste landfills. Comment By: 9/10/99.

Docket No. **16-0101-9904**, Rules for the Control of Air Pollution in Idaho. Updates rules to reflect changes in federal regulations that are incorporated by reference. Comment By: 9/10/99.

Docket No. **16-0106-9701**, Solid Waste Management Rules and Standards. Rewrite of chapter defines and clarifies requirements for the management, processing, waste handling, and disposal of non-municipal solid waste. Comment By: 8/25/99

Docket No. **16-0106-9901**, Solid Waste Management Rules and Standards. Proposed repeal of existing chapter. Comment By: 8/25/99.

Docket No. **16-0108-9802**, Rules for Public Drinking Water Systems. Adopts and implements a public drinking water system operator certification program based on EPA guideline standards and would require operators to be certified. Comment By: 8/25/99.

Docket No. **16-0108-9901**, Rules for Public Drinking Water Systems. Conforms to EPA regulations for turbidity standards; requires monitoring of individual filters in treatment plants; sets limits on disinfection byproduct

concentrations in finished drinking water and prescribes treatment techniques for water systems that exceed those limits; requires all community water systems to provide an annual water quality report to their customers; adds new definitions and implements 1998 amendments to the public records statute. Comment By: 8/25/99.

Docket No. **16-0210-9901**, Idaho Reportable Diseases. Changes incorporate new developments in disease reporting that have occurred nationwide. Comment By: 8/25/99.

Docket No. **16-0310-9902**, Rules Governing Medicaid Provider Reimbursement in Idaho. Implements the provisions of Senate Bill 1074 which changes the method of payment for nursing homes in Idaho to a prospective, acuity-based reimbursement system. Comment By: 8/25/99.

Docket No. **16-0319-9901**, Rules Governing Certified Family Homes. Establishes a standard set of requirements for safety, supervision, and care of the elderly or individuals with a physical disability, mental illness, or developmental disability for all residential facilities. Comment By: 8/25/99.

Docket No. **16-0322-9901**, Rules for Licensed Residential and Assisted Living Facilities In Idaho. Establishes a standard set of requirements for safety, supervision, and care of the elderly or individuals with a physical disability, mental illness, or developmental disability for all residential facilities. Comment By: 8/25/99.

**IDAPA 18 – DEPARTMENT OF INSURANCE
P. O. Box 83720, Boise, ID 83720-0043**

Docket No. **18-0126-9901**, Managed Care Reform Act. Implements and interprets the “Any Willing Provider Law” as it relates to Managed Care Organizations. Comment By: 8/26/99.

Docket No. **18-0169-9901**, Rule to Implement the Small Employer Health Insurance Availability Act. Removes language making Small Employer Health Insurance Availability Act provisions applicable to those holding individual policies where premium is paid by employer in whole or part; removes prohibition directed at agents and brokers; removes obsolete provisions concerning small employer health benefit plans. Comment By: 8/25/99.

**IDAPA 22 – IDAHO STATE BOARD OF MEDICINE
PO Box 83720, Boise, ID 83720-0058**

Docket No. **22-0101-9901**, Rules of the Board of Medicine for Licensure to Practice Medicine. Establishes annual continuing medical education (CME) requirements for physicians and CME compliance will be reported on annual license renewal application. Comment By: 8/25/99.

**IDAPA 24 – BUREAU OF OCCUPATIONAL LICENCES
1109 Main Street, Suite 220, Boise, Idaho 83702**

Docket No. **24-1901-9901**, Rules of the Board of Residential Care Facility Administrators. Establishes that the examination will be administered on the second Tuesday in January, April, July and October of each year. Comment By: 8/25/99.

**IDAPA 31 – IDAHO PUBLIC UTILITIES COMMISSION
PO Box 83720, Boise, ID 83702-5983**

Docket No. **31-7101-9901**, Railroad Clearance Rules. Lowers minimum vertical clearance required over railroad tracks from 23 feet 6 inches to "the vertical clearance required by the owner of the railroad tracks or 22 feet 6 inches, whichever is greater". Comment By: 8/25/99.

**IDAPA 35 – IDAHO STATE TAX COMMISSION
800 Park, Plaza IV, P.O. Box 36, Boise, ID 83722**

Docket No. **35-0102-9901**, Idaho State Sales and Use Tax Rules. Promoters of certain types of events are required to check for Seller's Permits for participating vendors and to issue temporary permits when necessary. Comments By: 8/25/99.

Docket No. **35-0104-9901**, Idaho Estate and Transfer Tax Rules. Updates provisions on electronic funds transfer pursuant to Idaho Code and updates references to rules. Comment By: 8/25/99.

Docket No. **35-0110-9901**, Idaho Cigarette and Tobacco Products Tax Rules. Meets statutory requirement to ascertain the amount of tax paid on cigarettes made by manufacturers who are not participants in the "Master Settlement Agreement". Comment By: 8/25/99.

Docket No. **35-0111-9901**, Idaho Unclaimed Property Rules. Requires payments of abandoned property over \$100,000 be made by electronic funds transfer pursuant to Idaho Code. Comment By: 8/25/99.

PUBLIC HEARINGS - Public Hearings have been scheduled for the following dockets:

State Board of Education

Docket No. **08-0203-9902**, Rules Governing Thoroughness.

Department of Health and Welfare

Docket No. **16-0101-9901** and **16-0101-9904**, Rules for the Control of Air Pollution in Idaho.

Docket No. **16-0106-9701** and **16-0106-9901**, Solid Waste Management Rules and Standards.

Docket No. **16-0319-9901**, Rules Governing Certified Family Homes.

Docket No. **16-0322-9901**, Rules for Licensed Residential and Assisted Living Facilities In Idaho.

Department of Insurance

Docket No. **18-0126-9901**, Managed Care Reform Act.

Please refer to the Idaho Administrative Bulletin, **August 4, 1999, Volume 99-8** for notices and text of all rulemakings, public hearing schedules, governor's executive orders, and agency contact names.

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